MARKET RESEARCH FOR PROVIDERS AND OTHER PARTNERS

FINAL REPORT ON HOSPITAL COMMUNICATION

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EXECUTIVE SUMMARY

Purpose

The Health Care Financing Administration (HCFA) has initiated a comprehensive strategy to coordinate existing communication activities within HCFA and develop innovative, effective approaches that make information accessible to all program participants. To develop these strategies for hospitals participating in the Medicare, HCFA funded this study to conduct Market Research for Hospitals. This research is designed to answer two central questions:

1. What information do hospitals need and want from HCFA?
2. How can this information be most effectively made available?

Background

There are over 5,100 Medicare-certified short stay hospitals in the United States. Hospitals represent a diverse group of health care providers which differ with respect to their mission, ownership, complexity and size, competitive environment, populations served, financial situation, physical facility, and patient costs. The information needs of a hospital and the process by which these needs may be met are largely dictated by hospital characteristics. Several trends in the hospital market are changing the way hospitals acquire knowledge and adapt operations, including: the increasing prevalence of Medicare managed care; consolidations, acquisitions, and mergers within the hospital market; and the integration of hospital services with other types of care to form health systems and community networks.

Hospitals licensed in their state of operations may apply to participate in the Medicare program. The processes through which the conditions for participation in Medicare are initially verified, and the periodic surveys necessary for monitoring, vary depending upon whether the facility is accredited by a nationally recognized accrediting body with deemed authority. However, all hospitals participating in the Medicare program must comply with the same general operational requirements and complete the same ongoing Medicare processes. It is during ongoing operations that hospitals have the greatest need for communication with HCFA and its contractors.

Methods

The approach taken to identify the information needs and most effective communication strategies for hospitals included:

- Convening a Hospital Advisory Panel composed of representatives from hospital industry organizations, hospital operational and management staff, and representatives from HCFA Central and Regional Offices to provide detailed input on research methods and issues to examine;
- Meetings with HCFA staff in the Central Office to gather information on current interactions among HCFA's divisions and with hospitals to develop a conceptual model of existing information flows and communication;

- A literature review to identify issues that were raised within the hospital sector concerning interactions with HCFA and information sought by the hospital industry from HCFA;
- Unstructured interviews with representatives of HCFA Regional Offices, fiscal intermediaries (FIs), hospital industry associations, and individual hospitals to obtain background and guidance on current information flows, information needs, and communication strategies;
- Site visits to Atlanta, Chicago, and San Francisco to obtain in-depth knowledge of current hospital operations and interactions with HCFA. These site visits included meetings with HCFA Regional Office staff, FIs, state survey agencies, and others; and
- Focus groups with hospital and FI staff to gather more information on issues identified during the interviews and site visits.

Findings

Hospitals and other interviewees identified key areas in which communications between HCFA and hospitals serving Medicare beneficiaries could be improved either by changing the nature of existing communication processes and materials or by instituting new communication strategies. Findings from the market research were synthesized into seven major communications issues and areas for improvement, including those related to:

- *Currency and accuracy of materials* - Hospitals report that HCFA provides a wide range of materials but that these materials are sometimes out of date or contain inaccurate information;
- *Timeliness of communications* - Hospitals need timely information in order to meet HCFA requirements and resolve issues before they become problems. At present, hospitals report that they frequently do not receive information, and/or answers to their questions, in time to prepare for changes in policy and requirements;
- *Consistency and coordination* - Hospitals report that there are differences in understanding and interpretation of policy and regulations among HCFA offices and across FI regions;
- *Simplification of communications* - Information provided by HCFA is often difficult for hospitals to access, complex and confusing, or requires great effort to ensure that the information accessed is complete and up-to-date;
- *Availability of information* - While HCFA makes much information available to hospitals, there is additional information that, if available, would help hospitals to operate more effectively and efficiently;
- *Information dissemination* - Hospitals suggested several strategies, in addition to those currently employed by HCFA and its contractors, that would increase the effectiveness of information dissemination and meet the needs of different types of hospitals; and
- *Consultations with the hospital industry* - Hospitals would like to have increased involvement in development of policy and new regulations, as well as participating in joint efforts with HCFA to improve operations of the Medicare program.

Hospitals, and other related organizations, provided specific and detailed suggestions to address these issues and improve communications, as well as examples of their communications needs.

PURPOSE

The Health Care Financing Administration is conducting market research to understand the information needs of Medicare beneficiaries, providers, managed care plans, and others who interact with the Medicare program. Information gathered through this market research will be used to coordinate existing HCFA communication activities and to develop innovative new approaches to assist all program participants in accessing Medicare information. Creating a far-reaching and innovative approach to meet these strategic objectives requires an enhanced understanding of providers' current experience with HCFA's role in administering the Medicare program, as well as their information needs.

This project, "Market Research for Providers and Other Partners," is providing a foundation of information to assist in the development of these strategies for hospitals, physicians, and other partners that serve Medicare beneficiaries. The study addresses two central questions:

1. What information do providers and other partners need and want from HCFA?
2. How can this information be most effectively made available?

The broad goals of HCFA's communication strategy reach beyond providing easily accessible information on Medicare benefits and coverage. HCFA could become a source of information to Medicare beneficiaries and providers on a variety of topics aimed at improving and maintaining health status and quality of life, including health promotion and prevention approaches, treatment options for medical conditions, and other issues that concern an aging and/or disabled population. The methods used to collect information from HCFA, hospitals and other organizations to assess information needs and to identify effective command action strategies are described in Appendix E.

The initial three groups selected by HCFA as the subjects of the "Market Research for Providers and Other Partners" project were: hospitals, physicians, and managed care organizations that contract with the Medicare program. The focus of this report is the information needs of hospitals that provide inpatient care to Medicare beneficiaries and the means by which this information can best be conveyed to multiple and diverse actors within hospitals across the United States.

BACKGROUND

There are over 5,100 Medicare-certified short stay hospitals in the United States. Hospitals represent a diverse group of health care providers which differ with respect to their mission, ownership, complexity, size, competitive environment, population served, financial situation, physical facility, and patient costs. About half of all hospitals have fewer than 100 beds. Fifty-eight percent of hospitals are voluntary; voluntary hospitals account for three-quarters of all Medicare payments. Over half of all hospitals are located in urban areas. About 23 percent of hospitals are certified by HCFA as teaching hospitals. In FY 1996, inpatient and outpatient hospital care throughout the country accounted for over $115 billion in Medicare funds.[1]

Hospitals represent the largest share of national health spending. As Medicare is the largest single payer for hospital care, the program's policies have an important impact on the financial performance of hospitals. Another force, the growth of managed care and Medicare risk contracting, also has had an impact on hospital performance. Managed care organizations have reduced inpatient hospital utilization and negotiated price discounts for their members. Hospitals have been seeking alternative sources of revenue by broadening the scope of services they offer and by integrating their services with those of other providers to increase market share.

Changes in the Hospital Market

Recently, several trends in the hospital market have begun to change the way hospitals acquire knowledge and adapt operations.

- The prevalence of managed care is increasing in many areas of the country. This new environment has different interpretations of "medical necessity" than fee-for-service insurance. For hospitals, managed care organizations increase cost containment pressures by reducing inpatient stays and negotiating price discounts or capitated rates for hospital services.
- Consolidations, acquisitions, and mergers within the hospital market are changing the nature of hospital competition. Corporations and chains are purchasing small, non-profit community and rural hospitals that have difficulty competing on their own. Such market concentration changes communications structures by centralizing authority and resources.
- Hospitals are integrating hospital services with other types of care to form health systems and community networks. Integration allows hospitals to better coordinate patient care and establish partnerships with clinics, physician practices, skilled nursing facilities, home health agencies, etc. to increase efficiency in operations. Many hospitals own other types of facilities as a way of diversifying their income sources and diffusing hospital overhead costs.

All of these changes have implications for how HCFA communicates with hospitals. HCFA may want to anticipate and build in the ability to adapt to new communications linkages. Additionally, methods could be tailored to improve communications with particular types of

[1] Estimate includes capital and durable medical equipment, as well as PPS and non-PPS facilities.

hospitals. HCFA has taken the first step towards such flexibility by seeking to understand how hospitals assess the effectiveness of communications and their needs for information.

HCFA and Hospital Communications

Hospitals licensed in their state of operations may apply to participate in the Medicare program. The processes through which the conditions for participation in Medicare are initially verified, and the periodic surveys necessary for monitoring, vary depending upon whether the facility is accredited by a nationally recognized accrediting body with deemed authority. Regardless of how they meet the conditions for participation, all hospitals participating in the Medicare program must comply with the same general operational requirements and complete the same ongoing Medicare certification processes. It is during the ongoing operations that hospitals have the most contact with and need for communication with HCFA and its contractors.

Hospitals have ongoing needs for information and communication with HCFA in order to operate successfully and to remain in compliance with HCFA standards. Information from HCFA comes from a number of different sources, including:

- The HCFA Central Office in Baltimore,
- The HCFA Regional Offices,
- Fiscal Intermediaries,
- State Survey Agencies, and
- Peer Review Organizations.

Hospitals are responsible for obtaining, understanding, integrating, and operationalizing information received from all these sources and for seeking clarification of specific aspects of Medicare processes, when necessary.

Certification and Accreditation Processes

Most organizations in the hospital market have a long-term, established relationship with HCFA initiated at some point in the past by the Medicare certification process. Since there are relatively few new hospitals established across the country in any given year, certification of new hospitals is not a major component of HCFA's communications. However, interviewees in various areas of the country reported a marked increase in the number of Medicare certifications that must be reissued under the name of a new legal entity to account for a change in ownership. Hospitals also noted their involvement in the certification of hospital-owned subacute and ancillary providers.

There are two ways in which a hospital can participate in Medicare: (1) meet the Medicare health and safety requirements (conditions of participation) as verified by an initial HCFA inspection and periodic surveys by the State survey agency. Or, (2) participate by virtue of its accredited status. Accreditation organizations with deeming authority take the responsibility for ensuring that hospitals receiving accreditation are in compliance with Medicare certification requirements as well as other additional industry-wide standards established outside of the Medicare program.

This way, accredited hospitals are engaged in a single review process for both HCFA and industry standards that does not directly involve HCFA or its contractors.

Currently, the two major organizations with deeming authority for Medicare acute care hospitals are the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA). JCAHO accreditation, held by roughly 70 to 80 percent of hospitals in the Medicare program, is increasingly important as a recognition of quality in the hospital market. Growth in the proportion of JCAHO hospitals can, in part, be attributed to the expansion of the managed care market where accreditation is often required for credentialing.

Ongoing Operations

Once a hospital is certified to participate in the Medicare program, ongoing Medicare operations require continuing interaction and information exchange between the hospital and HCFA. Both the HCFA Central Office (HCFA CO) and the Regional Offices (RO) have specific responsibilities with respect to communication with the hospital. HCFA delegates almost all financial and quality responsibilities to its contractors, the FIs and PROs, that work directly with the hospitals. A Medicare hospital maintains close communications with HCFA, and its contractors, on an ongoing and periodic basis for the following functions and requirements:

- Cost Reports and Audits. Medicare hospitals submit an annual cost report to the FI which details the organization's finances and is the basis for calculating the hospital's Medicare rate. Cost reports provide information that is used to determine what, if any special supplemental payments the hospital will receive beyond straight DRG reimbursement, such as graduate medical education funding or disproportionate share hospital payments. FI staff conduct desk report and on-site audits to verify the accuracy of a hospital's cost report. The audit team may make adjustments, when necessary, to the hospital's Medicare rate.
- Claims Processing and Reimbursement. Billing staff at hospitals submit claims to the FI either on paper or through electronic data interchange. Each FI uses one of two major claims processing systems, the Arkansas or Florida shared system, to interact with the FI. Hospitals receive remittance advices at least weekly from the FI which detail claims paid versus rejected. Denied claims can be corrected or appealed by the hospital.
- New Regulations and Changes in Policy. HCFA's Central Office has responsibility for developing new regulations based on legislation and for making changes in existing regulations. In some cases, hospitals are requested to participate in and to provide data, information, or comment for regulations-in-development. New regulations are translated at HCFA CO into the form of manual instructions, and transmitted to ROs. Each RO may clarify or add to information received from HCFA CO before sending it on to the FIs in its region. Each FI creates operational instructions for implementing the new policy and distributes these to hospitals in their service area through monthly bulletins or newsletters.

Other Potential Interactions and Optional Activities

In addition to the required aspects of participation in the Medicare program, a hospital may also interact with HCFA on any of the following optional or special case processes:

- Quality Improvement Projects. Hospitals may provide information to or participate in quality improvement initiatives that are developed and led primarily by PROs. Some national initiatives and campaigns are directed by the HCFA Central Office.
- Appeals of Cost Report Adjustments. If a hospital is dissatisfied with adjustments made to its annual cost report during the audit process and is unable to resolve these issues with FI auditors, then it may appeal FI decisions to a higher authority. The Blue Cross and Blue Shield Association, the prime contractor for FI services, handles appeals of adjustments under $10,000. The Provider Reimbursement Review Board (PRRB) at HCFA CO hears cases involving $10,000 or more. The appeal process includes an opportunity for both sides to formally state their opinions and negotiate a possible settlement before appearing at a hearing.
- Beneficiary Complaint Investigations. Beneficiary complaints are investigated either by the appropriate HCFA Regional Office and/or the state survey agency, with possible involvement of the local PRO in cases where judgments concerning medical necessity or appropriate medical practice are involved. The structure of the complaint investigation process varies somewhat from state to state but generally the RO is responsible for approving initial investigations and final decisions which are investigated by the state survey agency. COBRA violation investigations may take on a different format in some regions.
- Fraud and Abuse Investigations. There are several levels of fraud and abuse investigations in which a hospital may become involved. FI medical review units identify hospitals with repeated errors or problems with claims. This FI first attempts correction action to educate hospital staff of the proper way to file and code problem claims. If education does not resolve the problems, then the FI Program Integrity Unit is involved. If this unit detects fraud and abuse, it may report the hospital to the Office of Inspector General (OIG) for a full-scale fraud and abuse investigation. Some investigations may be initiated by OIG or a HCFA Regional Office in response to national or local concerns of widespread fraud and abuse. These investigations may target hospitals of special concern to OIG and/or the RO or may involve a random sample of hospitals in the area.

Appendix E describes and depicts the ongoing process of communication with Medicare hospitals and the interactions between HCFA, its contractors, and hospitals in more detail.

FINDINGS

Hospitals and other interviewees identified key areas in which communications between HCFA and hospitals serving Medicare beneficiaries could be improved either by changing the nature of existing communication processes and materials or by instituting new communication strategies. The findings section of this report is divided into sections pertaining to the following communications issues and areas for improvement:

- Currency and accuracy of materials,
- Timeliness of communications,
- Consistency and coordination,
- Simplification of communications,
- Availability of information,
- Information dissemination, and
- Consultations with the hospital industry.

Currency and Accuracy of Materials

Hospitals report that HCFA provides a wide range of materials but that these materials are sometimes out of date or contain inaccurate information.(See Table 1)

Clear and accessible information on Part A operations of the Medicare program is very important to the smooth functioning of the program for HCFA beneficiaries and for participating hospitals. As almost every interviewed hospital mentioned, HCFA often cites the various manuals discussing the Part A line of business as major information sources for several key operational areas. Hospitals use the manuals for details of how to operate their Medicare line of business. Currently, HCFA manuals may contain inaccurate information, are poorly organized, and are difficult to maintain. Of particular concern is that there have been changes in laws and regulations that have yet to be reflected in the Manual. As a result, basic information and requirements for operational areas are not available in a complete, accurate, and easily accessible form for hospitals.

Interviewees indicated that the HCFA manuals would be improved by:

- Updating the contents of the manuals to reflect changes in regulations and policies, including incorporation of the revised information requested on annual cost reports and, as appropriate, RO-specific policy memoranda and instructions to FI auditors;
- Employing a more systematic and regularly scheduled means of updating all policy and operational information.

Interviewees recommended that HCFA establish a system to update the manuals on a regular and timely basis. HCFA could consider implementing a schedule by which sections of each manual are revised. Additionally, hospitals encouraged HCFA to adopt practices that would facilitate the upkeep of manuals. If manual transmittals were to arrive at hospitals on a regularly scheduled basis, then organizations receiving transmittals would be able to track whether each edition has

arrived and periodically budget time to assimilate new information. Currently, the timing of transmittals is sporadic and transmittals for some manuals are too numerous to track effectively.

Table 1 Issues Related to Currency and Accuracy of Materials

General Issue	Specific Issues	Suggested Changes
Hospitals report that HCFA provides a wide range of materials but that these materials are sometimes out of date or contain inaccurate information.	1. Policy and operational requirements change frequently, but HCFA updates materials only infrequently and does not have a regular schedule for providing updates.	♦ HCFA should update materials on a scheduled basis and announce this schedule, so that hospitals can track these updates to ensure that they are current. ♦ Each Manual update should be created as a replacement for specific sections of the current Manual to allow hospitals to discard old sections and insert updates. ♦ HCFA should update the CD-ROM version of the Manual as frequently as the hard copy Manual is updated. ♦ HCFA should also make all policy and regulatory updates available through the HCFA Web Site to allow hospitals to ensure that they have the most current information.
	2. Hospitals would like current information on regulations in development or recently implemented so that they can participate in the development process and better prepare for changes.	♦ HCFA should publish, on a regular basis, a matrix showing all policies and regulations currently out for comment and the deadlines for receipt of feedback.

Hospitals also recommended that HCFA replace whole sections of the manual when making revisions rather than, for instance, sending revisions to a portion of a chapter. The current system for updating manuals is difficult, as the maintainer must carefully identify which sections are being replaced and cannot simply drop in each transmittal. Currently, a single transmittal may contain changes to numerous non-contiguous manual sections. Both hospitals and FIs would like to be able to pull out an old section and drop in the new one.

According to hospitals, one example of an area where the currency of HCFA materials lags behind operational deadlines is in the provision of certain basic instructions for completing cost reports. Namely, a set of cost report instructions is available in advance of hospital filing deadlines but may not reflect changes in regulations and new policy interpretations to be used by FI auditors. For the hospital, this means that the instructions by which they complete cost reports are not the same as the actual requirements for that year's filing. HCFA should provide complete, up-to-date instructions prior to the time when hospitals must use these instructions to complete a cost report.

In addition to lags in updating the hardcopy version of HCFA manuals, updates to the CD-ROM containing HCFA manuals are completed some time after those same changes are reflected in the hardcopy versions of manuals. Hospitals suggested that HCFA update its CD-ROM as frequently as on-paper manual transmittals are released.

Hospitals suggested that policy and regulatory updates could be made available through the HCFA Web Site. If such on-line distribution was consistent, then hospitals could use the HCFA Web Site to ensure that they have the most current policy information.

Comment periods for various regulations are difficult to track, as this information is not available in one location. Hospitals requested that HCFA publish, on a regular basis, a matrix showing all policies currently out for comment and the deadlines for receipt of feedback. Hospitals would like current information on regulations in development, or recently implemented, so that they can participate in the development process and better prepare for changes. The availability of such information through the HCFA Web Site is currently sporadic and deadlines are dispersed in various files and subject areas rather than displayed for quick reference. Ideally, such information would be updated weekly.

Timeliness of Communications

Hospitals need timely information in order to meet HCFA requirements and resolve issues before they become problems. At present, hospitals report that they frequently find that they do not receive information in time to operationalize changes in policy and requirements prior to implementation dates of changes. In addition, delays in receiving answers to questions may result in hospitals failing to meet specific HCFA requirements on time or submitting inadequate or incorrect information to HCFA or the FI. (See Table 2)

Interviewees raised a variety of issues concerning the timeliness of HCFA oversight and evaluation methods. They stressed the relationship of timely feedback on performance from

HCFA with the ability of organizations to learn from their mistakes and meet operational deadlines. Hospitals also raised some concerns that untimely communications may create unfair situations for hospitals.

The timing of HCFA communications not only affects hospital operations but may also affect beneficiaries directly. Hospitals requested that HCFA notify them of claims payments, partial denials, and denials before mailing an EOMB to the beneficiary. Hospital staff added, with concern, that receiving an EOMB for denied services can be especially distressing to the beneficiary. Such distress is unnecessary in many cases and could be avoided by building in a short response time between when the hospital receives notification of a partial or full denial and when an EOMB is generated. Currently, the beneficiary may receive information on a denial before the hospital does, leaving the hospital ill-prepared to answer and resolve concerns as beneficiary inquiries arrive.

Hospitals rely on HCFA and FI personnel to provide clarifications and interpretations of Medicare policy. Many times, hospital operations cannot be altered to come into compliance with new policies until answers to questions of interpretations are received. Almost all hospitals interviewed noted examples of situations where they did not receive a policy clarification or interpretation in time to meet either Medicare or hospital operational deadlines, such as cost report submission deadlines or situations of beneficiary medical decision making.

Interviewees stressed that the general timeliness of response to inquiries, especially in the face of established deadlines, could be improved both at the regional and national level. They recommended that HCFA establish customer service standards for timeliness of response to spoken and written correspondence addressed to HCFA and its contractors. Hospitals encouraged HCFA to use call and letter tracking to monitor personnel performance in these areas. It was noted that a tracking system could not only prevent inquiries from getting lost within HCFA operations, but could also allow particularly time sensitive correspondence to be flagged. Also, if HCFA and contractor personnel displayed increased sensitivity to the time constraints of hospitals by discussing projected response times with callers, then hospitals would feel less concerned. The caller would be better informed as to when they might receive a response, and HCFA, or its contractors, would be aware of any operational deadlines the hospital faced.

Some of the difficulties in reaching HCFA or contractor staff, reported by interviewees, were more mechanical in nature. Hospitals suggested that HCFA establish HCFA and contractor standards for phone communication, including:

- Maximum wait time on hold;
- Explanation of the reason for transferring call to another individual prior to initiating transfer;
- Designation of an alternate contact on all individual voice mail outgoing messages; and
- Access to an operator within the voicemail system.

Hospitals also requested that HCFA require contractor staff to respond to inquiries from consultants and other hospital-designated representatives with the same standards as those expected for hospital staff inquiries.

Both HCFA contractors and hospitals encouraged HCFA to provide adequate advance notice of implementation of changes in policies affecting hospital operations. Hospitals encouraged HCFA to improve the timeliness of the delivery of information on changes in policy from HCFA to the FIs. Sometimes hospitals receive notice of policy changes via FI bulletins after implementation dates have already passed. By this time, some hospitals will already have had claims denied or will be unable to make necessary systems changes before denials occur. Many hospitals must revert to manual billing or hold onto bills for a time until programmers can make the appropriate systems changes. Two examples of retroactive announcements cited repeatedly by hospitals are: 1) the release of the revised reimbursement policies for cardiac catheter services, and 2) changes to indirect billing.

Hospitals feel that it is too difficult to correct problems or errors in claims. This difficulty is compounded when a batch of claims is submitted incorrectly as a result of not receiving notification of a policy change. Once the hospital receives retroactive notification of the policy change it does not have an efficient way to correct such a volume of claims. It may take months for a hospital to correct problem claims (e.g., deductibles for inpatient blood). These claims remain suspended in the system and add to the hospital's accounts receivable. Delays particularly create problems for small hospitals that sometimes make payrolls based on HCFA reimbursements.

In addition to providing notice of changes, hospitals emphasized the importance of developing clear protocols for operationalizing policy in advance of implementation. Hospitals complimented HCFA on improving the timing with which it informs the industry of major changes. However, industry representatives cautioned HCFA that it must be prepared to present operational details of new policies at the time major changes are explained to the hospital community. They recommended producing audit guidelines detailing HCFA expectations as a framework for hospitals to implement new policies.

Hospitals and FIs raised some additional recommendations pertaining to timeliness:

- Inform hospitals of their Medicare rates prior to the beginning of the new rate year. Current delays prevent hospitals from completing accurate budget planning.
- Set and adhere to timeframes for completing cost report audits to ensure that evaluation occurs based on the same policy interpretations in existence at the time of filing; and
- Eliminate the practice of charging interest on credit balance adjudications of cost reports since most delays are related to the time it takes FI auditors to complete reports. Numerous interviewees commented on the "unfair" nature of HCFA interest policies.

Hospitals also indicated that some information supplied by HCFA is not available on a real-time basis and therefore delays or impedes hospital operations. Hospitals should be able to access up-

to-date PS&R data at any time during the year. PS&R data are currently made available 120 days after the close of the fiscal year and do not contain information on claims whose processing was delayed for medical review. Hospitals not only need PS&R data to complete current cost reports, but also to stay apprised of how older cost reports will be settled, since settlements are based upon PS&R data that are no more than six months old.

Table 2: Issues Related to Timeliness of Communications

General Issue	Specific Issues	Suggested Changes
Hospitals need timely information in order to meet HCFA requirements and resolve issues before they become problems. At present, hospitals report that they frequently find that they do not receive information in time to operationalize changes in policy and requirements prior to implementation dates of changes. In addition, delays in receiving answers to questions may result in hospitals failing to meet specific HCFA requirements on time or submitting inadequate or incorrect information to HCFA or the FI.	1. Medicare beneficiaries sometimes receive EOMB statements prior to the hospital receiving notification from the FI that a claim has been made. If the beneficiary then calls the hospital with questions or concerns, the hospital cannot assist them since they do not have information on the claim.	♦ EOMBs should be timed to ensure that hospitals receive payment information prior to, or at the same time as, beneficiaries receive the EOMB.
	2. When hospitals contact HCFA or the FI with a specific request for information or clarification of rules, either by phone or in writing, it often takes an extended time period before the hospital receives an answer to their inquiry. In some cases, the hospital must make repeated inquiries before an answer is forthcoming.	♦ HCFA should establish standards for FI and HCFA staff timeliness of response to spoken and written correspondence with hospitals. Special standards should be established for inquiries that are related to FI or HCFA established deadlines that hospitals must meet
	3. When hospitals contact HCFA or the FI by telephone, it often takes a great deal of time to reach the appropriate person, with busy signals, extensive numbers of rings, and the hospital may be passed from voice mail to voice mail, or person to person before reaching the appropriate person. Sometimes numerous calls must be made because no one answers or it is not possible to reach a 'real' person to explain the nature of the call.	♦ HCFA should establish standards for phone communication for FI and HCFA staff, including wait time on hold, explanation of call transfer, designation of alternate point of contact, and access to an operator.

General Issue	Specific Issues	Suggested Changes
	4. HCFA sometimes issues new rules and regulations that require major changes in hospital operations a very short time before the effective date, which makes it impossible for hospitals to meet the deadline.	♦ HCFA should develop a process for setting the timeframe for implementation of changes in policy and requirements that recognizes the time required by hospitals to make significant operational changes. ♦ HCFA should seek input from hospitals on the time that will be needed by the average hospital, and by different subsets of hospitals, in order to implement new regulations. The schedule for development on guidelines and disseminating new requirements should be determined in advance, and the implementation schedule should be determined based on this timeframe.
	5. Hospitals sometimes do not receive information on their new Medicare rates and the calculation process prior to the new year. This makes it difficult for hospitals to plan and for hospitals to ensure that they are submitting accurate claims.	♦ HCFA should officially inform hospitals of their Medicare rate and calculations well in advance of the beginning of the year.
	6. Delays in conducting audits and in reporting audit results to hospitals sometimes cause serious problems for hospitals.	♦ HCFA should set and monitor timeframes for completing audits of cost reports to ensure that the audit is based on the same policy interpretation that existed at the time the cost report was filed. ♦ If an extended delay in audits of cost reports occurs, hospitals should not be subject to penalties or interest that extends back several years because of these delays.
	7. Some information supplied by HCFA is not available on a real-time basis and therefore delays or impedes hospital operations.	♦ Hospitals should be able to access up-to-date PS&R data at any time during the year.

Consistency and Coordination

Hospitals report that there are differences in understanding and interpretation of policy and regulations among HCFA offices and across FI regions.(See Table 3)

A major issue raised by hospitals and others interviewees was a lack of consistency across regions in the information received by and interactions with hospitals. A number of organizations indicated that the most significant barriers to consistent communication between HCFA, HCFA contractors, and hospitals are related to differences in staff knowledge, organizational experience, and operational structures across regions. From the hospital perspective, many HCFA and FI staff do not possess the knowledge of hospital operations or medical decisionmaking that is necessary to consistently supervise/evaluate hospital performance in the Medicare program, including providing interpretations of medical coverage policy during focused medical reviews. HCFA CO, ROs, and FIs also expressed concerns with the level of knowledge of their own staff and the lack of shared knowledge across regions. Most interviewees suggested that consistency and coordination across regions could be improved if HCFA were to standardize certain aspects of regional operations. Specific requests for consistency included development of standardized:

- FI customer service and education mechanisms, such as a beneficiary hotline;
- Worksheets, publicly released audit guidelines, and definitions of terminology for problem areas in FI audits, such as MSP investigations and ISIS; and
- Process standards for completing FI duties, such as conducting an entrance and exit interview with hospital staff during a cost report audit.

Responsibility for developing uniform guidelines for all FIs in specific areas should be assigned to an accountable individual in HCFA's Central Office, who would also be responsible for ensuring that new interpretations and guidelines are disseminated to all RO and FI staff.

For example, almost all of the hospitals interviewed had suggestions of how to improve consistency in the FI audit process. The most common comments were that on-site visits took too long to accomplish and that the need for follow-up investigations or questions should be reduced. Additionally, hospitals would like FI auditors to:

- Eliminate the need to request the same information more than once,
- Complete desk audits to direct and limit the audit process prior to the site visit,
- Narrow scope of the audit by focusing on reviewing abnormalities between this year and last,
- Detail adjustments and reasons why these adjustments were made in their work papers,
- Try to reach an agreement on all disputed issues before closing the audit process,
- Avoid waiting until close to the end of the fiscal year to resolve outstanding issues, and
- Implement the cost report audit timeframes established by MTAG and enforce FI compliance with these expectations.

There are also coordination challenges involved in the delivery of information from HCFA to its contractors. In particular, some information does not flow to all parties that could benefit from it, established information processes are not always followed, and some communications responsibilities are not fully delineated.

Comments on the consistency and coordination in communication with contractors, included:

- Both HCFA CO and RO staff requested that communications paths be established to ensure that policy clarifications made in response to individual inquiries at HCFA CO are disseminated to ROs and vice versa. This type of information sharing sometimes occurs but is not routine and is important not only for consistency but also to avoid duplication of effort.
- There are problems with consistent usage of the designated communication path between HCFA CO and FIs. RO, FI, and hospital interviewees noted that HCFA CO established a mechanism by which information flowed from HCFA CO through the RO to the FI. However, this mechanism is not always followed leaving various ROs and FIs to find out about missing information after it should have been distributed to them. HCFA should more clearly delineate the flow of information and the responsibilities of each type of organization in initiating communications steps.
- The current system for disseminating policy and regulatory information from HCFA CO to hospitals involves duplication of effort in each region, which not only creates inefficiencies but also may contribute to inconsistencies in interpretation across regions. Hospitals recommended simplifying the distribution process by creating operational instructions centrally rather than separately at each RO and FI.
- HCFA should develop specific requirements for RO oversight and interaction with hospitals and should define areas of accountability for the RO. This should also include standardization of the division of labor between ROs and state survey agencies across the country.
- Each RO and HCFA contractor should be required to designate organizational contacts for key hospital policy and operational areas who can receive all information from HCFA and take responsibility for its internal distribution to appropriate personnel. FIs and ROs using this system found that they were better able to direct the flow of information into, within, and out of their operations.
- HCFA should develop a more formal and frequent system for general training and ongoing education of RO and FI staff on regulations and policy interpretations. An important foundation to any training program would be the institution of training/background requirements for certain types of personnel. Suggestions for training methods included restarting 'leadership conferences' and holding regular teleconferences between FIs and ROs.

Once clear standards and guidelines are established, and individuals are assigned responsibilities for key areas of policy and operational decision making, HCFA should provide this information to all hospitals, FIs, and ROs to facilitate appropriate communications and to direct inquiries to the responsible individual.

PROs and state survey agencies urged HCFA to define consistent quality standards to be employed in both PRO and state survey agency work. Both types of contractors are aware of inconsistencies in the emphasis of PRO versus state survey agency quality standards. Hospital interviewees also felt that all HCFA contractors should have the same quality goals and emphasize the same areas for improvement.

Table 3: Issues of Consistency and Coordination

General Issue	Specific Issues	Suggested Changes
Hospitals report that there are differences in understanding and interpretation of policy and regulations among HCFA offices and across FI regions.	1. It appears to hospitals that the HCFA Central Office does not have clearly established standards and requirements that direct the work of Fiscal Intermediaries and that establish the responsibilities of Regional Offices. As a result, hospitals in different areas may be subject to different processes and standards.	♦ HCFA should develop clear standards and guidelines for FI operations and staff responsibilities, with directions for the FI to contact HCFA for clarification of 'gray' areas. Responsibility for developing uniform guidelines for all FI s in specific areas should be assigned to an accountable individual in HCFA's Central Office, who would also be responsible for ensuring that new interpretations and guidelines are disseminated to all RO staff and to all FI staff. ♦ The HCFA Central Office should establish a process for monitoring and oversight of FI activities and RO processes to ensure that consistency and coordination exists nationally. ♦ HCFA should develop specific requirements for RO oversight and interaction with hospitals and should define areas of accountability for the RO. This should also include standardization of the division of labor between ROs and state survey agencies across the country. ♦ HCFA should require FIs and ROs to designate specific individuals who are responsible for coordinating and ensuring consistency on key policy and operational areas for hospitals. ♦ HCFA should develop a more formal and more frequent system for training FI staff and for educating them on changes in policy and requirements and new interpretations of specific areas. ♦ HCFA should restart the 'leadership conferences' and support regular teleconferences with ROs. ♦ Once clear standards and guidelines are established, and individuals are assigned responsibilities for key areas of policy and operational decisionmaking, HCFA should provide this information to all hospitals, FIs, and ROs to facilitate appropriate communications and to direct inquiries to the responsible individual.

General Issue	Specific Issues	Suggested Changes
	2. PRO and RO activities related to quality of care differ across geographic areas and sometimes result in inconsistent direction and application of quality processes and requirements for hospitals.	♦ HCFA's Central Office should define specific and uniform quality standards to be used by all PROs and state survey agencies. ♦ HCFA should clearly define the division of responsibility between PROs and Regional Offices and require that ROs designate a key liaison person who is responsible for ensuring consistency and providing oversight to PRO activities. ♦ HCFA should disseminate all HCFA policy and regulatory information to PROs to assist them to understand issues and to clarify 'gray' areas.
	3. Because different FI audit teams may be assigned to specific hospitals each year, hospitals report inconsistencies in expectations and processes from one year to the next in their cost report and financial audits.	♦ A specific FI audit team should be assigned to each hospital on a continuing basis to allow a consistent working relationship to be developed and to ensure consistency across years.

Hospitals did comment that some of the variation in regional operations is necessary due to the different characteristics of markets in each region. For instance, interviewees encouraged HCFA to allow for variation in PRO relationships with their provider communities but also cautioned HCFA to ensure that no one type of provider is shortchanged in terms of PRO interaction and accessibility.

The new organization of PRO oversight by ROs has led to some communications difficulties according to RO and PRO staff. HCFA should improve communication between PROs, ROs responsible for oversight, and other ROs not directly active in PRO oversight. All parties involved should at a minimum, be aware of PRO activities and regional performance expectations/goals.

HCFA contractors, especially PROs, would like to receive all Medicare hospital information and not just that information which is specific to their line of work. A broader understanding of the Medicare program and HCFA's goals would help contractors coordinate with each other and be consistent with HCFA CO intentions.

Hospitals raised a consistency issue regarding the FI audit process. One hospital remarked that it had done intensive work with FI auditors to develop an appropriate system for identifying and handling MSP situations only to be told during the next annual audit that the new system was insufficient and non-compliant with HCFA regulations. Several hospitals added that each institution spends time discussing its organizational structure and business processes with FI auditors before auditors are able to fully understand the cost report. This information must be repeated each year and any decisions made the year before may or may not be supported by the next audit team. Interviewees suggested that these inconsistencies could be solved if HCFA were to assign each hospital to a specific FI audit team that would conduct all annual cost report audits and focused medical reviews for that hospital. Such a system would enable hospitals and FI auditors to develop effective working relationships and reduce the amount of time auditors spent at each hospital on an annual basis.

Simplification of Communications

Information provided by HCFA is often difficult for hospitals to access, complex and confusing, or requires great effort to ensure that the information accessed is complete and up-to-date.(See Table 4)

Organization of Written Information

Interviewees noted that most HCFA publications cite or reference another publication, often making it difficult to find a clear answer to a specific operational question. It was suggested that references to other documents need to be accompanied by a short description of the relevance and content of the suggested source. Without such information, hospitals feel they do not have adequate information to decide whether the reference will be helpful in answering their specific questions. Hospitals encouraged HCFA to realize that providers need a certain level of detail in order to answer an individual question or address a specific problem, and to write publications that would enable providers to locate details.

Hospitals suggested that HCFA always repeat information needed to fully understand the broader policy issue and use a standardized cross-referencing system where citations are accompanied by enough information to determine their basic content. Standardization is an important element as HCFA documents evolve over time. Various publications currently contain some contradictory citations as a result of updating only some documents or revising the format for certain types of documents. Consolidating text on program areas and coverage issues would avoid the need to pull information scattered throughout different sections, and across various manuals, in order to have a complete and accurate picture of requirements. Including an annotated index by subject area in each manual and providing a comprehensive index across manuals for Medicare Part A, in general, would also assist hospitals in finding other references to the same subject matter.

Current problems with the structure and content of HCFA manuals make use of the CD-ROM version difficult. Benefits of having a CD-ROM are overridden by problems in finding the location of information. In addition to revising HCFA manuals themselves, hospitals proposed the following adaptations to the CD-ROM versions of these manuals:

- Add the ability to search by topic to the CD-ROM search device;
- Use hypertext links to cross-reference documents and sections on the CD-ROM; and
- Employ a commercial vendor to revise and maintain the CD-ROM version of the manuals.

Hospitals suggested that HCFA consider contracting out the duty of revising and maintaining the CD-ROM to an established commercial vendor. Most of the interviewee comments listed above are at least in part derived from expectations of CD-ROM performance acquired through hospital experience with commercially produced CD-ROMs of HCFA materials. Most interviewees were familiar with such commercial products and many emphasized that commercially produced CD-ROMs of HCFA materials are much more user friendly than the one produced by HCFA.

Much of the information provided to hospitals regarding the Medicare program is delivered through HCFA contractors. In particular, FI communications are an essential link from HCFA to hospitals in the delivery of operational information related to claims processing and reimbursement. Interviewed hospitals provided some feedback to HCFA on FI performance in the area of written communications. Some hospitals felt that FI communications were friendly and useful while others hesitated to offer praise. Some of the variation in opinion is derived from differences in individual FI performance and relationships with hospitals. Hospitals that were generally satisfied with FI communications cited a friendly tone and detailed indices as reasons why publications, such as FI users guides for claims and billing systems, were appreciated.

Increasing Clarity

Another suggestion from hospital staff focused on the difference between legal versus operational documents. Most hospitals expressed a need for more operational language in HCFA publications. These interviewees believe that some of the terminology employed in HCFA operational materials, though it may be appropriate from a legal standpoint, is less than helpful in determining the exact meaning of the operational instructions. Hospitals requested that HCFA

make language clearer, use simple wording, and focus explanations on ways in which policies and regulations affect hospital operations.

Table 4: Simplification of Communications

General Issue	Specific Issues	Suggested Changes
Information provided by HCFA is often difficult for hospitals to access, complex and confusing, or requires great effort to ensure that the information accessed is complete and up-to-date.	1. Information related to a specific issue may require searching several documents or checking in several sections of a specific document. Hospitals have no way to determine whether they have identified all relevant information related to the topic of concern.	♦ HCFA should develop informational materials that completely address specific issues in one document. Cross-references to related documents should be provided, but these related documents should provide background rather than critical information on the specific issue. These topic-specific informational materials should be organized to allow up-dates to be inserted when issued and all informational material should contain dates to facilitate determination of which information is most current. ♦ HCFA should provide indexes for Manuals and for the CD-ROM versions that allow hospitals to quickly ascertain all relevant sections of these materials that relate to specific issues of interest. ♦ The HCFA CD-ROM should be made more 'user friendly' by including mechanisms for searching by topic and cross-referencing documents and sections. ♦ All HCFA manuals should use a standardized system of cross-referencing. ♦ FI user's guides for claims and billing systems should also be made more 'user friendly' through the addition of detailed indexes that allow hospitals to ensure that they have identified all relevant sections.
	2. HCFA information materials lack clarity and are sometimes confusing and filled with jargon that is difficult to interpret.	♦ HCFA should develop explicit definitions of terminology used in Manuals and cost reporting guidelines and publish a Glossary of these terms.
	3. Hospitals frequently have difficulty identifying the appropriate person at the CO, RO, or FI to contact about specific topics.	♦ HCFA should require that each FI and RO identify key contact persons for specific topic areas and disseminate that information to hospitals. ♦ It would also be helpful if each FI and RO assigned a specific staff person to each hospital to act as a liaison and assist the hospital to reach the appropriate person to resolve issues and problems.

General Issue	Specific Issues	Suggested Changes
	4. HCFA information may be directed to different people within a hospital with the result that hospitals can not be sure that they have received all information. Hospitals that are part of chains may receive some information, while the central chain headquarters may receive other information.	♦ HCFA's CO, RO, PRO, a...l FI offices should standardize their systems for sending correspondence to hospitals. Hospitals should be permitted to designate specific individuals within the hospital to receive different types of correspondence (. e.g., PRO information would be sent to the hospital's quality contact.) ♦ Hospital chains should be allowed to designate a hospital-specific and corporate liaison to receive all communications. ♦ HCFA should establish a regular timeframe for updating hospital contact information and inform hospitals in advance of this deadline to ensure that current and accurate contact information is maintained.

For example, vague terminology both in the HCFA manual and FI bulletins appears to contribute to misunderstandings between hospitals and HCFA intermediaries. Words, such as "reasonable" and "appropriate" when used as a qualifying term in policy implementation instructions, lead to a wide variety of interpretations of the limits for those instructions. What an FI surveyor views as reasonable is likely to differ from what the hospitals view as reasonable due to the different environments in which these individuals operate.

In particular, hospitals would like to receive more detailed "working definitions" of terms whose definitions affect the way certain hospital elements are counted on cost report worksheets. "Working definitions" should not only include descriptions of the meaning of the term but also advise hospitals on how to account for circumstances that occur frequently yet fall into the "gray areas" of interpretation. Examples of terminology used in cost report instructions without an adequate "working definition" include:

- Graduate medical education (GME) "1st, 2nd, and 3rd year resident" categories for which cost report instructions do not contain an explanation of how to account for residents who change status or switch programs during the HCFA fiscal year, which incorporates portions of two academic years; and
- The types of hospital beds that can be counted as "available beds." This term is sometimes defined by FI auditors as synonymous to Medicare certified beds and other times not.

As hospitals evolve into more complex organizations the cost reporting process increases in detail and is prone to errors. Small differences in the methodology for completing the cost report can translate into large changes in the payments hospitals receive. For these reasons, the cost report and FI cost report audit process are recognized as a crucial part of Medicare operations by both hospitals and HCFA.

Identifying Contacts

Hospitals commented that decisionmaking within the Medicare program on interpretations of less common policy situations is the area in which most response delays occur. When RO or HCFA CO consultation is required, delays can occur not only due to the time it takes to place calls and provide background information to additional people, but also due to problems in finding the right individual with the authority to make a decision. According to hospitals and HCFA contractors, decisionmaking could be facilitated by creating a special communication path for resolving less common policy interpretations. Key features of the communication path would be designated HCFA personnel and a defined process for specifying any time constraints. Such a system would also be more supportive and fair for HCFA employees who currently may be pressured to make judgment calls without the proper authority or background to do so.

Hospitals often spend significant amounts of time trying to reach the appropriate RO or FI staff person who can respond to inquiries and make decisions. It would be helpful if HCFA required ROs and FIs to provide a list of staff who have responsibility for specific areas and issues, and designate experts on "hot issues." Such personnel should be able to offer policy interpretations in their area and work with CO on an as-needed basis to resolve difficult issues. It would also be

helpful if each FI and RO assigned a specific staff person to each hospital to act as a liaison and assist the hospital to reach the appropriate person to resolve issues and problems.

Correspondence

Hospitals noted that HCFA information may be directed to different people within a hospital with the result that the organization can not be sure that it has received all information. Hospitals that are part of chains may receive some information, while the central chain headquarters may receive other information. HCFA's CO, RO, PRO, and FI offices should standardize their systems for sending correspondence to hospitals. Hospitals should be permitted to designate specific individuals within the hospital to receive different types of correspondence (.e.g., PRO information would be sent to the hospital's quality contact). Interviewees also requested that chain hospitals be allowed to designate a hospital specific and corporate liaison on HCFA communications databases. This way HCFA could carbon copy the designated liaison on all Medicare communications and keep both levels of the corporation adequately informed.

HCFA communications systems also need to be updated in a timely fashion. Hospitals cited problems in receiving HCFA materials that were caused by out of date mailing lists. One hospital reported that its HCFA mailings come addressed to the hospital administrator who retired 5 years ago. Interviewees asked that HCFA regularly update hospital mailing lists based on the information hospitals give to HCFA that reflects changes in hospital leadership and new organizational relationships.

Additional Information

While HCFA makes much information available to hospitals, there is additional information that, if available, would help hospitals to operate more effectively and efficiently.(See Table 5)

Hospitals receive extensive information from the Health Care Financing Administration (HCFA) both in terms of background knowledge for Medicare operations and of ongoing information concerning policy changes and new regulations. In addition to general communications, HCFA and contractor staff handle a wide variety of inquiries from individual hospitals. Direct communications center on responding to inquiries or resolving issues by providing clarifications or interpretations of requirements.

This section of the report focuses on the information needs of acute care hospitals which, according to those hospitals, Regional Offices (ROs), fiscal intermediaries (FIs), state survey agencies, peer review organizations (PROs), and industry associations interviewed, are currently not met by HCFA and its contractors. It is possible that some of the information described in this chapter as missing is actually available through HCFA, its contractors, or its publications. However, if hospitals do not know of the availability of such information then there is an opportunity for improving the process for informing hospitals that the information exists and where/how it can be accessed. While the information needs of different types of hospitals vary, there are areas in which many of the hospitals and other organizations interviewed agreed that

additional information would facilitate more efficient Medicare operations in hospitals. The findings for seven areas of information needs are summarized in Table 5 and elaborated below.

Table 5: Additional Information that Hospitals Would Like to Have Available

General Issue	Specific Information Requested by Hospitals
While HCFA makes much information available to hospitals, there is additional information that, if available, would help hospitals to operate more effectively and efficiently.	*Information Related to Medicare HMOs:* On-line access to a database that would allow hospitals to identify Medicare HMO members when they arrive at the hospital. ♦ Identify to hospitals all Medicare HMOs operating in their market areas. ♦ Medicare HMO policies for providing emergent care ♦ Policies that determine HMO payments to non-contracted hospitals when they provide services to HMO members. ♦ Appeals procedures when a hospital has a payment dispute with a Medicare HMO. *Information on Utilization, Outcomes, and Quality of Care* ♦ Summary statistics on utilization and outcome data for each hospital's market area, overall and for the individual hospital *Information on Claims and Billing Issues* ♦ Detailed information on remittance advices that allows hospitals to determine specific claims that were designated as overpayments and coding for payment reductions. ♦ Detailed description of the PPS and its use to calculate specific payments. *Information Provided to Medicare Beneficiaries* ♦ Hospitals would like to receive copies of all general information sent by HCFA to Medicare beneficiaries, in order to assist beneficiaries who may have difficulty understanding changes in the Medicare program. ♦ Information on the new HCFA beneficiary toll-free telephone number that could be used by hospitals to assist beneficiaries to obtain information.

General Issue	Specific Information Requested by Hospitals
	Information Related to New Policies and Regulations ◆ Hospitals would like to receive background information on new policies and regulations that clearly explain the objectives of the changes and the process through which the change will be implemented. *Information on HCFA Activities and Organizational Changes* ◆ Information on conferences where HCFA staff are scheduled to discuss specific issues ◆ Information on HCFA pilot programs and demonstrations that hospitals may want to participate in or may need to be aware of to assist beneficiaries to understand these programs. ◆ Information on HCFA organizational structure and planned and implemented changes in structure. ◆ Information on new and developing regulatory initiatives, to permit hospitals to participate in the process and to understand new programs.

Information Related to Medicare HMOs

Virtually all hospitals interviewed provide services to some Medicare HMO enrollees. Depending upon a hospital's relationships with Medicare HMOs in its area, the hospital may have access to a variety of HMO information or be completely unaware of the most basic information needed to serve HMO enrollees. Without adequate information on Medicare HMOs, hospitals may not be able to comply with HMO policies or to collect payment from the HMO. Nearly all of the hospitals interviewed requested that HCFA provide some additional information on Medicare HMOs. In new markets where managed care enrollment is on the rise, hospitals are particularly confused by the number of new plans and need extra assistance from HCFA. Hospitals located in more developed managed care markets must spend considerable time compiling plan specific information and are more likely to be part of one or more HMO provider networks.

Since managed care information is dynamic during this time of rapid expansion in and changes to the Medicare HMO program, hospitals recommended that HCFA create an on-line database or interface to provide up-to-date information on Medicare HMOs and enrollment. Interviewees recommended that such an interface allow hospitals to:

- Identify an individual as a current member of a particular Medicare HMO at the time the beneficiary arrives at the hospital;
- Generate a list all Medicare HMOs operating within a given market area with contact numbers for Medicare member services and billing departments;
- Obtain Medicare HMO policies, both general to the Medicare HMO program and any specific to the plan, for providing emergent care to beneficiaries; and
- Access information on appeal procedures for hospital payment disputes with Medicare HMOs.

Many hospitals expressed confusion regarding HCFA policies on HMO payments to non-contracted hospitals providing services to HMO members. These hospitals are unclear whether they are entitled to receive reimbursement for out-of-network care equivalent to standard Medicare fee-for-service payments. Apparently, Medicare HMOs sometimes reimburse hospitals for only part of the standard prospective DRG payment and may refuse attempts by the hospital to collect the remainder. While such HMO practices may not be condoned by Medicare HMO regulations, hospitals lack information on HCFA requirements and are therefore not able to identify when and if remaining amounts can be legally claimed.

Information on Utilization, Outcomes, and Quality of Care

One perception of HCFA in the hospital research community is that it has a large store of data and health services research information that is not made available to the public. In particular, hospitals would appreciate HCFA sharing utilization and outcomes information with the provider community. For example, Health Care Investments Analysts (HCIA) inpatient utilization data, or MEDPAR data, is not available to hospitals for research unless the hospital pays HCFA to perform a data run. Since hospitals are collecting HCIA inpatient utilization data on HCFA's

behalf, they feel that HCFA should be able to make summary statistics available to them and perform limited data analysis that the majority of the hospital community would find useful.

Information on Claims and Billing Issues

A number of hospitals interviewed noted that remittance advices do not currently provide all the information a hospital must have to understand how a claim was paid. Remittance advices could be improved by providing an adequate explanation of the coding for payment reductions, including: the year, the reason payment was reduced, and concise definitions of codes. This information is difficult to obtain when not provided on the remittance advice. Hospitals may be able to look up definitions of codes yet still may not have enough information on the reason the payment was reduced. Such information is essential to understanding and correcting staff errors.

Additionally, hospitals requested that HCFA provide a description of the exact process by which Medicare hospital rates are calculated so that a hospital can use this information to calculate a tentative rate while completing its cost report.

Information Provided to Medicare Beneficiaries

Hospitals would like to receive any information disseminated to other participants in the Medicare program, including fiscal intermediaries and carriers, physicians, Medicare risk health plans, and beneficiaries. For example, receiving beneficiary communications would help hospitals to assist beneficiaries in understanding changes in the program and how best to access benefits. Some hospitals, who had heard about the new HCFA beneficiary 1-800 # encouraged HCFA to disseminate information on the new toll free beneficiary service line to hospitals so they can include it in their outreach activities.

Information Related to New Policies and Regulations

Almost all interviewees noted that by including more detailed information in the original publication of regulations HCFA could reduce both the number of clarifications sought by hospitals and the amount of variation in interpretation of regulations by hospitals and HCFA contractors. Information at the level of detail necessary for operationalizing policy is currently not provided proactively from HCFA to hospitals, but instead is created by FIs and ROs in response to individual inquiries. In particular, some interpretations are only included in FI audit guidelines or in HCFA memoranda, both of which are not released to hospitals. HCFA's interpretation of OBRA regulations for Medicare SNF bed certification is one example cited by interviewees. Currently, much of this information is contained in internal policy memos which are believed by some interviewees to be contradictory to the policy interpretations enforced by state survey agencies responsible for certifying SNF beds.

Hospitals suggested that Medicare regulations could provide better operational guidance to hospitals if HCFA were to include the following additional detailed information:

- Discussions of the intention behind new legislation and policy to help hospitals and intermediary personnel preserve the meaning of regulations as they interpret the way policies affect their particular operations; and

- Simple "how to" directions for operationalizing policy with explanations of how hospital operational performance of the regulation will be evaluated.

Without detailed operational information on new policies, hospitals may not understand how to comply with regulations or may misinterpret the intention behind regulations. These deficiencies can lead to uncertainty for hospital personnel who do not know if hospital operations are in compliance with HCFA regulations and fear that they may face fraud/abuse charges due to misunderstandings.

Information on HCFA Activities and Organizational Changes

Hospitals, as well as other interviewed groups, would also like to be better informed of HCFA activities and initiatives. This would not only assist hospitals in preparing for change, but would also provide hospitals with information that could be shared with beneficiaries. Interviewees indicated that HCFA has numerous initiatives underway, and it would be helpful to receive information on their status. In particular, hospitals would like the opportunity to apply to participate in HCFA demonstration and pilot projects. Some examples of hospital remarks include:

- HCFA recently started a pilot program in New York State to investigate new ways of structuring GME payments to hospitals. All of the teaching hospitals and AMCs interviewed asked to receive more information on the structure of the program and wanted to know how HCFA had chosen the location and hospitals for the pilot;
- Hospitals are unclear how HCFA intends to proceed with implementing the proposed new Medicare Transaction System. Originally, hospitals expected HCFA to create a new claims processing system but now the Agency is requiring all hospitals to use the Florida Shared System. Some interviewees believe that switching to the Florida Shared System is unwarranted given the amount of time it will take to make the transition and the uncertain rewards of doing so. They would like to know if another system will be implemented later or if HCFA has plans to improve the Florida Shared System;
- Hospitals have not heard of the results of the FI Audit Process Medicare Technical Advisory Group (MTAG) survey which they were asked to complete some time ago. A few hospitals interviewed reported having seen the list of conclusions from the overall MTAG and HCFA effort to redo the FI audit process. None of the hospitals we spoke with were aware of the implementation of any recommendations from this initiative; and
- Hospitals are currently seeking information and updates on the HCFA reorganization.

It would also assist hospitals if HCFA were to regularly provide information on its organizational structure of the Agency and key contacts within HCFA by operational and/or topical area, with e-mail addresses and telephone numbers. This would enable hospitals to communicate more effectively with appropriate HCFA staff. Many interviewees indicated that this information is mostly acquired through personal contacts and should be made more widely available. Some hospitals indicated the need to know when their key HCFA staff contacts are going to be out of the office, such as changing their voice mails to indicate the length of their absence and, just as critical, identifying an appropriate back-up person in their absence. Hospitals would also like

information on the conferences where HCFA staff are scheduled to speak and the specific issues that they will be addressing.

Information Dissemination

HCFA and FIs currently communicate with hospitals through a number of different strategies. Hospitals suggested several additional strategies that would increase the effectiveness of information dissemination and meet the needs of different types of hospitals. (See Table 6)

HCFA provides a large amount of information to hospitals, using a number of different communication methods. These include:

- Written materials,
- Verbal communication, by telephone and in-person,
- HCFA Web Site,
- E-mail and electronic data transfers, and
- Conferences and training.

Hospitals and other interviewees were asked about communications strategies that would be most effective for HCFA to use to improve information flow and communication to improve the process and assist the hospitals and HCFA to work more smoothly and efficiently. While effective communication strategies may differ for hospitals with different characteristics, all of the hospitals had suggestions for changes in communication strategies that they believed would improve the process. Table 6 summarizes the major recommendations made by those who were interviewed during this project.

The consensus among the hospitals and others that were interviewed is that HCFA currently employs some effective communication strategies and that hospitals could obtain most information that is essential for effective operations of a hospital. The suggestions that were provided would expand the use of some types of communication strategies, diversify the strategies used to convey some types of information, and make certain specialized information more accessible to the hospitals that need it most. Since hospitals have different methods of internal communication based upon their organizational characteristics, offering information through multiple communication methods would increase the ability of all hospitals to obtain information and work effectively with HCFA.

Table 6: Information Dissemination

General Issue	Specific Suggestions
HCFA and FIs currently communicate with hospitals through a number of different strategies. Hospitals suggested several additional strategies that would increase the effectiveness of information dissemination and meet the needs of different types of hospitals.	*Training Sessions and Materials*: ◆ Develop telephone training sessions on specific topics. These are offered by some FIs, are useful, and offer hospitals the opportunity to raise hospital-specific issues. In addition, these training sessions are easier to participate in than are in-person workshops and conferences, particularly for small and rural hospitals. ◆ Prepare short videocassette presentations to assist hospitals in understanding complex Medicare issues (e.g. a video on the 72-Hour Rule, with descriptions and clear examples of how these regulations apply to emergency room staff). ◆ Distribute computerized training sessions on diskettes, for specific topics. ◆ Offer tutorials as a component of current systems to help users understand processes (e.g., as part of the claims filing system). ◆ Offer more FI workshops on basic Medicare and as background for major policy changes. While these are offered currently by some FIs and on some topics, a more fully developed program on a regular schedule in all areas would be helpful to many hospitals. *On-Line Communications*: ◆ In general, hospitals would like to see HCFA and the FIs provide more information on-line and to have on-line information updated on a regular schedule. ◆ Hospitals would like to have interactive, on-line communication with HCFA and FIs, where they could ask questions and provide training for hospital personnel. ◆ It would be useful for HCFA to develop listservs, e-mail news groups where members and the listserv administrator could post messages. This would allow hospitals to subscribe to specific types of information based on the characteristics of their organization.

General Issue	Specific Suggestions
	Written Communications: ◆ Publish a HCFA-sponsored newsletter that includes discussion of upcoming policy changes, HCFA initiatives, and other HCFA activities of interest to hospitals would be helpful. While there are a number of private newsletters, the information provided in them is often inaccurate and hospitals would prefer to receive information directly from HCFA. ◆ HCFA should create FAQ (frequently asked questions) fact sheets on specific issues and new policies and distribute them to FIs, ROs, and directly to hospitals on a regular basis. *Telephone*: ◆ HCFA should offer a national "update hotline," similar to those offered by some FIs, so that hospitals can call and obtain information on 'hot' issues and recent changes in policy. ◆ HCFA should publish a directory of individual hospitals that ROs and FIs should call in the Central Office for various types of information, including designated experts in specific operational and policy areas. *Targeted Information Dissemination*: ◆ Hospitals should be able to specify topics that they would like to receive information on and HCFA should then target information dissemination by topic to specific hospitals.

Consultations with the Hospital Industry

Hospitals would like to have increased involvement in development of policy and new regulations, as well as participating in joint efforts with HCFA to improve operations of the Medicare program. (See Table 7)

Hospitals suggested that HCFA work more closely with individuals in the industry to incorporate operational knowledge and perspectives into both the development of policy and the improvement of the Medicare program operations. Increased collaboration with the hospital industry could be achieved both at the national and local levels.

As in many industries, health care providers are constantly evolving structurally and utilizing more advanced technologies in order to maintain their competitiveness. In general, hospital and contractor staff felt that HCFA does not understand the pace of structural and technological change within industry, the operational issues and constraints faced by hospitals and intermediaries, and the time needed to implement changes in operational procedures and information systems. Hospitals made the following suggestions to improve HCFA's ability to keep pace with industry and anticipate the operational impacts of changes in policy:

- Involve industry experts in the design and implementation of policy initiatives so as to harness capabilities already possessed by commercial entities and accurately assess the impacts of policies prior to implementation. HCFA could re-establish its use of Technical Advisory Groups (TAGs) during the development and implementation to incorporate industry expertise into the developmental phase, save time, and avoid potential implementation obstacles. It is imperative that HCFA design and implement policy initiatives quickly before technology becomes out of date. For example, hospitals suggested that if the Medicare Transaction System (MTS) had built upon systems and technology already available in commercial markets then the initiative would not have been so delayed; and
- Monitor and respond to operational and structural changes in industry that may diminish the effectiveness and intended effects of HCFA policies and regulations. Hospitals emphasized the importance of adapting regulations to new market structures and conditions of the industry before such regulations inhibit market evolution and innovation. This could be accomplished by maintaining contact with industry leaders to assess future directions. A current example cited by hospitals is the inability of Medicare regulations to provide guidance across the continuum of care that has developed in the hospital industry from acute to subacute to home health and the new financial relationships between different types of providers. HCFA should develop communication mechanisms for keeping industry and individual hospitals informed of progress and schedules for new initiatives and opportunities for hospitals to provide input.

At a more local level, hospitals urged HCFA and its contractors to form closer and more collaborative working relationships with the hospital industry. Some specific suggestions are listed in Table 7.

Table 7: Consultations with the Hospital Industry

General Issue	Specific Issues
Hospitals would like to have increased involvement in development of policy and new regulations, as well as participating in joint efforts with HCFA to improve operations of the Medicare program.	*Consultation on Policy and Regulation Development*: ♦ HCFA should re-establish it use of Technical Advisory Groups (TAGs) during the development and implementation of new regulations as a mechanism for assessing the impact of changes in policy. ♦ HCFA should develop communication mechanisms for keeping the industry and individual hospitals informed of progress and schedules for new regulatory and policy initiatives and opportunities for hospitals to comment and provide input. *Foster Closer and More Collaborative Working Relationships with the Industry*: ♦ HCFA should encourage PROs to form relationships with the hospital industry in each State in order to ensure that PROs involve the industry in development and implementation of programs. ♦ HCFA should encourage FIs to work closely with the hospital industry in each geographic region (e.g. FIs could participate in state and local health care councils and hospital meetings.) ♦ HCFA should encourage Regional Office staff to participate in local hospital industry conferences, including speaking at meetings on new policies and other special topics of current interest to hospitals. ♦ HCFA should partner with state hospital associations and other local groups to offer workshops on new policy and regulatory issues.

APPENDIX A

SUMMARY OF
HOSPITAL ADVISORY PANEL MEETING

HCFA Market Research for Providers and Other Partners
Hospital Module
First Advisory Panel Meeting
February 6, 1997; 9:30 a.m. - 3:00 p.m.

Meeting Participants By Organization

Panel Members	HCFA	Barents/Westat/ Project HOPE	Consultants
S. Ray Coffey	Charles R. Booth	Jo Ann Lamphere	Sharyn Sutton
Mary Elina Ferris	Vijaya A. Chilton	Laura Esslinger	Ray D. Sweeney
Linda Magno	Steven B. Clauser	W. Sherman Edwards	
Paul Rosenfeld	Joyce G. Somsak	Helen Gelband	
Margaret VanAmringe	Sherry A. Terrell	Garrett Moran	
		Tami Mark	
		Steve Parente	

The Hospital Advisory Panel meeting began with an overview of HCFA initiatives to improve communications and a description of objectives of the "Market Research for Providers and Other Partners" project. Health Care Financing Administration (HCFA) representatives emphasized the importance of understanding the information needs of hospitals and developing effective communication strategies that would meet those needs. The role of the Advisory Panel was discussed and the schedule of future activities for the project was laid out.

General Comments

- HCFA has some trouble communicating to hospitals in part as a consequence of mutual wariness between hospitals and HCFA due to the agency's regulatory role. While it is true that HCFA could improve communications by partnering with and creating new linkages with hospitals, it would be difficult for most hospitals to view HCFA as a partner at this point in time. Most hospitals view HCFA as an adversary: "HCFA is suspicious of hospitals and hospitals are suspicious of HCFA." There are areas where the structure of the Medicare program places HCFA in an adversarial relationship with hospitals, such as with cost disallowances and where HCFA's enforcement of regulations is at odds with hospital interpretation. Also, HCFA and hospitals experience a communication disconnect between policy development, dissemination, and implementation. The agency's history is one of policy decisions being made with limited opportunity for feedback from the provider community and transmitted to providers without strategies for effective implementation or feedback.
- Hospitals could view HCFA as more than simply a policy and regulatory body. HCFA could be an information broker, a purchaser, and an educator, as well. "Partnering" between HCFA and hospitals should be based on shared values--quality care, beneficiary/customer satisfaction, and cost control.

- Inventory tasks should be subdivided into major subject areas because communications issues vary significantly based on the operational area in question. Hospital operational areas such as finance and quality have very few common information needs and may require different communications strategies. Once categories are identified, project staff can focus inquiries towards the different types of hospital personnel within each operational area. HCFA will need to determine what information is needed in each category and who can best deliver this information. Suggested categories included:
  - ◊ General Communication
  - ◊ Fraud and Abuse
  - ◊ Legal and Regulatory Issues
  - ◊ Claims Processing and Billing
  - ◊ Reimbursement
  - ◊ Audits
  - ◊ Cost Reporting
  - ◊ Survey and Certification
  - ◊ Quality Assurance and Technical Denials
  - ◊ Benefits and Managed Care
  - ◊ Data Requirements
  - ◊ Beneficiary Services
  - ◊ Medical Records
  - ◊ CEO/CFO/Administration

Literature Review

- HCFA should evaluate its current policy communications tools, such as memoranda, the Code of Federal Regulations (CFR), and the Federal Register. According to the Advisory Panel members, these publications may or may not serve the majority of an individual hospital's information needs. There could be better ways of distributing policy information than those currently used. An inventory of current communications should ask:
  - ◊ What information is missing from existing communications?
  - ◊ What is wrong with the methods and processes of existing communications tools?

Interview and Site Visit Component

- Types of organizations and individuals to include in telephone interviews:
  - ◊ Associations
  - ◊ State survey and certification agencies
  - ◊ Hospitals
  - ◊ Academic medical centers
  - ◊ HCFA Regional Offices (ROs)
  - ◊ Accrediting bodies
  - ◊ Consultants/Accountants
  - ◊ Post-acute care facilities
  - ◊ Peer Review Organizations (PROs)
  - ◊ Fiscal Intermediaries (FIs)
- Teaching hospitals and academic medical centers should be included in the interview and/or site visit components of the project because these organizations have specialized information needs. A recent "hot topic" in hospital communication with HCFA involves FI interpretation of billing regulations for teaching hospitals.
- The post-acute care continuum should be included in the inventory since it has specialized needs and impacts hospitals' care of Medicare beneficiaries. Communication between hospitals and HCFA about post-acute care issues is poor. HCFA needs to acknowledge the connections between post-acute care facilities and hospitals, namely that these facilities may be owned by hospitals or integrated into a health system with hospitals. For instance, HCFA

has convened meetings with home health care agencies, nursing homes, long term care facilities, etc. without inviting the American Hospital Association (AHA) to attend.

- Suggestions of organizations to interview:
  - ◊ American Association of Hospital Attorneys
  - ◊ National Health Lawyers Association (NHLA)
  - ◊ American Bar Association
  - ◊ Medical lawyers
  - ◊ American Health Information Management Association (AHIMA)
  - ◊ Consultants
  - ◊ Veterans Administration, hospital system
  - ◊ American Osteopathic Association (AOA)
  - ◊ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - ◊ Public Health Service, Office of Rural Health Policy
  - ◊ Volunteer Hospitals of America
  - ◊ University Hospital Consortium
  - ◊ Catholic Health Care West or other regional hospital systems
  - ◊ American Healthcare Quality Association (AHQA)
- Suggested questions for interviews:
  - ◊ What was the last communication you made with HCFA where you did not get a satisfactory response?
  - ◊ What inquiries would you like to make which you do not even bother making or are unsure to whom you should address?
  - ◊ What sources of information do you refer to?
  - ◊ How useful are current HCFA communications? What existing HCFA communications mechanisms do you find most helpful? most efficient?
  - ◊ Determine whether there are any existing mechanisms of which interviewees are not aware.
  - ◊ What is your view of HCFA Regional Offices (RO) and Central Office (CO), and of FIs?
  - ◊ Where can HCFA have some immediate successes with improving communications?
  - ◊ What communications mechanisms would you like to use, i.e. how would your organization like to communicate with HCFA?
  - ◊ How do you internally disseminate Medicare information received by your organization?
- Panel members did not feel that the number of beds in a hospital should be a major factor in the selection process for hospital site visits. Rather, they suggested that whether a hospital is part of a system or network is more important than the size of the individual hospital in determining their information needs and shaping their communications structures. An interview with a health system could help capture the different needs associated with various types of hospitals. In addition, members agreed that interviews should cover a diversity of hospitals by including variation in such characteristics as: specialties, teaching status, regions, urban/rural environments, and whether the hospital does its own billing.

- Site visits may also need to address communications issues specific to specialty hospitals. These issues can be identified through phone interviews with specialty associations.
- When selecting which ROs and FIs to visit, project staff could seek input from HCFA regarding the strength and weaknesses of each office's and intermediary's performance. Panel members commented that the quality of service delivered by the individual ROs/FIs varies greatly.
- Protocols for telephone interviews and site visits should be distributed to interviewees in advance of the actual interview so that participants can be prepared to discuss the issues.

Focus Groups

- Panel members proposed that the four types of focus groups should be conducted with four types of hospital personnel (representative of different operational areas) rather than with four types of hospitals. Operational areas discussed included: finance, quality, coding/data, law, managed care, and beneficiary communication. The panel unanimously agreed that focus groups separating hospital staff by functional area would promote more interactive discussion and provide project staff with more in depth information.
- Focus groups could address regional inconsistencies by including RO and FI staff. A teleconference with HCFA Regional Administrators could also be used to gather information on regional inconsistencies.
- FIs, PROs, and accreditation bodies provide information to hospitals and all need information from HCFA. Separate focus groups could be used to examine the needs of these organizations through whom HCFA indirectly communicates to hospitals.
- Suggestions of places to hold focus groups where a variety of hospital personnel gather:
  - ◊ Regional Association Meetings (pull different levels and types of hospital personnel together at different times, i.e. billing personnel separate from CEOs)
  - ◊ Healthcare Financial Management Association (HFMA) chapter meetings or HFMA National Meeting in June (FI and RO personnel; business managers, clerks, CFOs, and data entry specialists from hospitals)
  - ◊ JCAHO meetings (hospital risk managers, medical directors, and quality improvement personnel; host monthly meetings on different subject areas)
  - ◊ National Health Lawyers Association (NHLA) National Meeting in April (health and medical lawyers; deal with fraud/abuse, liability, regulation, risk management, and compliance issues)
  - ◊ Bureau of Program Operations (BPO) audit conferences (FI audit staff)
  - ◊ Fiscal Intermediary Groups' regular meetings at HCFA CO

Provider Survey

- Panel members suggested conducting a survey on-line by setting up a web page with an electronic form.
- Before doing a survey by mail, project staff would need to identify hospital contacts who can take responsibility for internally facilitating the completion of the survey by individuals

throughout the organization. This process of identifying individuals "in the loop" could only be done for a small sample.

- Panel members encouraged project staff to decide whether to conduct a survey based on the results from the focus groups.
- A survey would allow research to quantify and validate conclusions from the rest of the project.
- HCFA should consider doing a survey only after it has assimilated information from this project and are looking to design and test new communications strategies.
- The survey for this project could not "piggy-back" on the AHA annual survey because AHA is cutting back on its survey efforts and could not at this point expand its annual survey.
- It is possible that the answers to questions this project is asking are not quantifiable and that a survey would not significantly enhance or validate qualitative results from other phases of the project.

Communications Issues

Communication From Hospitals to HCFA

- Currently, the most valuable communications hospitals have with HCFA are made through individual contacts with HCFA staff members. The established communication strategy for hospitals is contacting "who you know." As information flow has become more complex, hospitals and HCFA both have recognized that communication reform is necessary. In addition, this informal system of communication places organizations without contacts at a significant disadvantage. Start-up organizations have particular difficulty identifying the right people to talk to within HCFA.
- Whether a hospital approaches the RO, the FI, or HCFA CO depends upon the nature of the inquiry:
    - ◊ Routine billing and reimbursement questions are addressed by the FI; and
    - ◊ Unusual inquiries are handled by the RO which may defer to HCFA CO; and
    - ◊ Clarification on inconsistencies or interpretations are addressed by HCFA CO.
- A hospital will approach HCFA CO directly when it is on a quest for consistency, such as instances where a hospital is cited for breaking regulations even though the hospital believes it followed written regulations or when a hospital receives different interpretations of the same regulation. In these cases, hospitals feel the need to go back to the individuals who created the policy in order to feel secure about answers received. Corporate chains and associations especially need to receive consistent answers to policy questions on which they can rely.
- Providers will only use communications methods through which they get timely responses. This means that HCFA should have different communication methods depending on the kind of information that is needed and its priority. Some issues are so important that hospitals

cannot wait for an answer. In these cases, such as license-threatening violations, HCFA needs to have a system that can make front-line policy determinations.

- A lack of front-line knowledge makes it difficult for HCFA staff to understand policy and operational issues from a hospital's point of view. Said one hospital representative, "While HCFA debates policy, life goes on and people are admitted to the hospital each new day. We experience an urgency in problem resolution that HCFA doesn't understand."
- Hospitals need a knowledgeable HCFA contact with whom they can develop a relationship and from whom they can receive consistent information. Currently, there are inconsistencies and disagreements in answers provided at the regional level (RO and FI) versus the national level. Many HCFA and FI staff members are not adequately informed of policies or properly trained to handle inquiries. As a result, many inquiries hit a bottleneck at the RO level till they are forwarded to HCFA CO. Creating a customer service directory with HCFA contacts listed by topical issue/operational area would facilitate hospital personnel directing inquiries to individuals who are able to answer their questions. This would prevent ROs from needing to direct/forward unanswered inquiries to HCFA CO. Furthermore, since all inquiries dealing with a particular subject would be addressed in the same area of HCFA, inconsistencies in answers could be reduced.

Communication From HCFA to Hospitals

- Poor intra-HCFA communication is the most serious problem providers face. Inconsistencies are created when policy must go through so many steps before reaching those who enforce it. Policies are incorporated in manuals from which instructions are generated for HCFA staff to use in interpreting individual situations. Therefore, there are three levels of interpretation before HCFA decides if providers are in compliance with regulations. The final interpretation of policy may not match the intent of the policymakers themselves.
- HCFA needs to develop a timely and consistent process for solving interpretation problems which it was not able to proactively avoid.
- HCFA often deals with the same issue or problem many times over in different locations rather than creating a solution or reaching a decision once, and then adopting it throughout the country. Once decisions are made, they should be "memorialized." HCFA needs to be careful not to go overboard with this suggestion. If every answer were to be repeated nationally then there would be a tendency to push all interpretations and clarifications to top levels of personnel.
- Much direct communication from HCFA is not received by the appropriate individual within each hospital. Identifying the proper individuals to receive various types of communications would improve the speed of information dissemination. More than one contact is needed at each hospital due to the variety of information/issues addressed in HCFA communications. The CEO or CFO cannot be expected to disseminate information throughout the organization. If HCFA wants to stick with a primary contact then it should be someone who is designated as the one individual who is responsible for and has knowledge of how to properly disseminate the information.

- Hospitals are often unclear from whom they will receive information because HCFA may use direct or indirect communication methods. For example, during the Cooperative Cardiovascular Project results were sent out to hospitals through PROs. On other occasions, HCFA has sent the same type of information directly to hospitals. Panel members were in agreement that such information should be distributed through PROs because those organizations have already identified the appropriate contacts within hospitals to receive it.
- Associations assume much of the responsibility for regular communications of HCFA news. Groups such as AHA communicate daily with hospital CEOs via broadcast faxes addressing "hot" issues. These groups also facilitate the flow of information from hospitals to HCFA by alerting HCFA to problems, emerging issues, and questions their members have. AHA has regional meetings with HCFA where collaborative agreements are developed, new issues are introduced, and existing policies are clarified. State associations are also involved in facilitating communication with HCFA in similar ways.
- A wide disparity among fiscal intermediaries (FIs) exists in terms of timeliness and quality of service. Furthermore, FIs do not always agree with each other or support one another's decisions. This lack of consistency is a barrier to the proper functioning of indirect communications hospitals make with HCFA through FIs. improvements could be made through better training of FI (and RO) staff concerning major or sensitive regulatory changes.
- PROs and deemed accreditation organizations (JCAHO and AOA) should work together to direct quality initiatives and goals within the hospital industry.

General Comments

- If HCFA commits to reform communications then it will need to follow through by actually delivering customer service. If hospitals contact HCFA and do not receive a response then they will write-off HCFA's desires to build communication as "lip service." In the past, HCFA has set up new systems which are not followed and, therefore, dry up and disappear.
- There is no single perfect communication strategy; different types of communication are necessary in order to connect with a variety of providers. At the same time, information provided by HCFA about Medicare needs to be consistent across all types of communications and through all points of contact. Workgroups may be an effective communication strategy for the implementation of new regulations.

Information Needs and Suggested Communications Strategies

- Hospitals would like HCFA to make more data available to them free of charge and in a user friendly format so that they do not have to buy HCFA data from consultants. For example, Medicare fee schedules need to include county designations so the user can do conversions/calculations.
- HCFA should develop a "best practices" guide for hospitals with detailed information on which practices are helpful for Medicare operations.

- Hospitals need more information on Medicare managed care. HMO benefits and standards of quality are very different than those in fee-for-service (FFS) Medicare. Panel members suggested that in the long run HCFA could help standardize utilization review practices and goals. In the short run, HCFA could facilitate interaction between their various types of partners, enabling these partners to communicate differences in standards.
- HCFA should recognize that HMOs and hospitals do have interests in some of the same issues, including: beneficiary communications, quality of care, customer service, cost-effective care, best practices, data sources, and comparative pricing data.
- HCFA could develop its role as an educator by creating linkages to other areas of Department of Health and Human Services (DHHS) and to other data systems.
- Working groups have helped hospital staff see issues from HCFA's point of view. They also help HCFA see the gaps between policy and reality.
- HCFA could offer a customer-friendly 1-800# for providers with a guaranteed follow-up system. This toll free number could serve as a clearinghouse and refer callers to the proper individuals to answer their questions. However, not all Medicare information can be provided at the national level. Hospitals need the operational and technical support of ROs to deal with regional issues.
- HCFA should continue to expand its on-line sources of information and to track "hits" as a source of feedback on the usefulness of various pieces of information provided on-line. It would be helpful to create a table of contents on the HCFA web page of the most common issues raised by hospitals. That way, hospitals would be able to access answers to common questions and information on "hot issues" without searching through the many pages of on-line material.
- On-line communication cannot replace written communication, particularly in the case of legal and regulatory issues. HCFA should reevaluate the types of communication it delivers on paper to prioritize pieces that are critical and to redo the format of any written communications that are not user friendly.
- HCFA should publish the Internet addresses of staff with whom hospital personnel are in contact.
- Improved communication linkages between HCFA bureaus and other entities, such as the Department of Justice, should be fostered.

Conclusion

The Hospital Advisory Panel shared the perspective that more collaboration exists between HCFA and hospitals now than in the past with respect to the development of public policy affecting the hospital industry. Panel members also agreed that a partnership has formed between the public and private sector in the policymaking process. The Panel was less certain of the meaning of partnership as it relates to policy dissemination and the day-to-day operations of hospitals and the federal government. Asked one Advisory Panel member, "are we still good partners if you disallow our costs?" Another member emphasized the opportunity for enhanced

communication between hospitals and HCFA in areas where values are shared, such as quality care for beneficiaries, cost-effective care, and commitment to quality in the delivery of customer services.

APPENDIX B

METHODS

APPENDIX B

METHODS

The activities under this project define the current information needs of hospitals and their common communication issues with HCFA. The multiple dimensions of hospitals as providers of care and as an important source of information to beneficiaries and also physicians are considered. This project examined hospitals' needs for different kinds of information, such as that related to reimbursement and quality care, and how existing communication patterns enhance or detract from the effective delivery of care to Medicare beneficiaries.

Under the "Market Research for Beneficiaries" project, the Barents Group team interviewed large private employers, senior groups, and managed care companies to identify innovative communication strategies that are used to reach beneficiaries. The findings on the information needs of Medicare beneficiaries are also relevant for identifying some of the information needs of hospitals because these entities need up-to-date knowledge to address question of patients about health care and to assist them in utilizing Medicare services in many settings.

Advisory Panel Meeting

An Advisory Panel of industry representatives was established to guide key decision making points of the project. Prior to beginning the hospital market research, a Panel meeting was convened on February 6, 1997. This Panel provided advice and guidance early in the inventory component of the project and recommended potential choices for site visits. A summary of the information provided to the project by Advisory Panel is contained in Appendix A to this report.

Several categories of expertise were sought from the panel, including: senior hospital executives who interact with HCFA; a representative of the American Hospital Association (AHA) who communicates with HCFA and assists hospitals in understanding HCFA rules and regulations; and representatives from a Peer Review Organization (PRO) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) who have an understanding of the communications strategies used to convey quality improvement information and regulations.

The following individuals are members of the Hospital Advisory Panel:

- Ray Coffey, National Director and Assistant Vice President of Health Financing Resources, Quorum Health Group, Inc.;
- Steven Cole, Vice President for Health Financing and Research, Federation of American Health Systems;
- Mary Ellina Ferris, M.D., Medicare Director for Southern California and Associate Clinical Coordinator, California Medical Review, Inc.;
- Tom Johnson, Vice President for Reimbursement, Columbia/HCA Healthcare Corporation;

- Paul Rosenfield, Executive Vice President for Special Populations and Continuing Care, Sisters of Charity Health System;
- Margaret Van Amringe, Director of Federal Relations, Joint Commission on Accreditation of Healthcare Organizations; and,
- Linda Magno, Policy Development, American Hospital Association.

In addition, two individuals agreed to serve as consultants to the project: Stephen M. Shortell from the Kellogg School of Management and Raymond Sweeney from the Hospital Association of New York State (HANYS).

Review of HCFA Materials and Communication Methods

The literature review for the Hospital Module had several components: a review of materials provided to hospitals about Medicare, such as notices in the Federal Register of changes in payment policy, billing practices, and anti-fraud regulations; and, a focused review of information provided by fiscal intermediaries and hospital associations and the role of these associations as intermediaries between HCFA and the hospital sector. Appendix C describes the literature search and review methodology used for this project.

The review of communications methods began on January 29, 1997 when project staff met with HCFA officials to learn from the HCFA perspective what information is provided and how communication with hospitals works. The initial overview meeting with HCFA staff from various bureaus helped project staff obtain a thorough understanding of these communications, to identify HCFA staff for further contact, and to identify outside entities to contact for more information.

Telephone Interviews

Telephone interviews were conducted with a number of organizations and individuals to obtain background information to structure the subsequent site visits. Principal types of organizations contacted included: organizations representing hospitals (e.g., the American Hospital Association); associations representing hospital professionals, such as administrators and attorneys (e.g., the American Academy of Hospital Attorneys and the Healthcare Financial Management Association); key personnel in hospitals (e.g., administrators and finance personnel); peer review organizations; and state survey and certification agencies. Telephone interviews with staff from several HCFA Regional Offices were also conducted to document their interactions with hospitals, intermediaries, and HCFA CO.

Site Visits

Using information from the Hospital Panel, the preliminary literature review, and telephone interviews, detailed interview guides were prepared for site visits to hospitals in Atlanta, Chicago, and San Francisco (see Appendix VII-A). The site visits identified information needs and effective mechanisms for communicating with subsets of hospitals with unique information needs. Organizational characteristics considered in the site selection process included: types of hospitals, including voluntary, proprietary, or government, chain or independent, teaching status,

and location (urban or rural). Advisory Panel members suggested that whether a hospital is part of a system or network is more important than the size of the individual hospital in determining their information needs and shaping their communications structures. They added that, because quality of service delivered by individual HCFA Regional Offices and fiscal intermediates varies greatly, site visits to different ROs and FIs should be sought.

In addition to one interview with a fiscal intermediary in the Washington, DC area and a rural hospital in South Dakota, site visits were conducted in: Atlanta, Georgia (March 11 to 12, 1997); Chicago, Illinois (March 17 to 18, 1997); and San Francisco, California (March 19 to 20, 1997).

Information was collected on information needs and communication strategies for the following categories of organizations:

Table B-1: Interviews and Site Visits

Organization	Number
HCFA Regional Offices	4
Hospitals	14
Fiscal Intermediaries	2
Industry Associations	7
Peer Review Organizations	3
State Survey Agencies	3

Table B-2: Characteristics of Hospitals Interviewed and Visited

Characteristic of Hospital	Number
Public	3
Private Chain	5
Private Independent	6
Voluntary	8
For-Profit	6
Academic Medical Center	3
Other teaching	5
Non-Teaching	6
Urban	11
Rural	3
Total	14

Focus Groups

Focus groups were conducted with hospital finance and FI personnel in several areas of the country. Discussion guides were developed to gather additional information on issues raised during the Hospital Advisory Panel meeting, literature review, telephone interviews, and site visits. During the focus groups, participants were asked to share their views and experiences on a

list of topics identified as areas where additional information or clarification on hospital and FI viewpoints would be helpful in further defining the findings of the hospital market research.

APPENDIX C

LITERATURE REVIEW

APPENDIX C

APPROACH TO REVIEW OF THE LITERATURE

A large number of information sources were screened as background to preparing the Hospital Inventory and to guide the development of the Interview and Site Visit Protocols for this project. These information sources included:

- Data bases, including MEDLARS and LEXUS NEXUS, were searched to identify literature and information sources on Hospital contracting/accreditation, information, communication, and application processes. This search turned up a large quantity of citations; however, none of the citations reviewed were useful for identifying the information needs of Hospitals or effective communication strategies.
- Newsletters and manuals directed toward Hospitals were identified and reviewed to determine whether they contained useful insights and information of the information needs and communication processes that are relevant to Hospitals interactions with HCFA. The focus of these articles was primarily on step-by-step operational compliance. No useful information for this project was found in these materials.
- HCFA materials that are disseminated to Hospitals were obtained and reviewed. This material provided the basis for understanding the information currently being provided by HCFA to Hospitals and for developing a framework for the process through which Hospitals are currently interacting with HCFA. This framework was then used to develop the Interview Guides and Site Visit Protocols that were used for the inventory and focus group components of the study.

Because no relevant information was identified in our search of the literature, no literature review was prepared for this project and included in this Inventory Report. Instead, the research team concentrated on reviewing HCFA materials in order to understand the current information flows and interactions and to assess current communication strategies. The results of this review are presented in Appendix E and formed the basis for developing the data collection strategy for the project.

APPENDIX D

INTERVIEW GUIDES

Interview Protocol for Hospitals

Target Questions:

What types of information do you require from HCFA about Medicare?

Which information needs does HCFA meet best?

Do you have unmet or poorly-met needs for information from HCFA?

From whom, other than HCFA, do you get useful information about HCFA and Medicare?

Information Needs of Hospitals

What categories of information do you require from HCFA?

Do you have formal or informal mechanisms for assessing your information needs? If yes, please describe these.

Do you get information about HCFA and Medicare from other sources (e.g., associations, fiscal intermediaries)? If yes, which ones, and what types of information do they provide?

Interactions With HCFA

From which HCFA offices do you receive information (in order of importance)?

From which HCFA offices do you request information (in order of importance)?
- How do you decide which office to contact?
- What types of information do you seek from each?

Does HCFA have mechanisms to regularly survey your information needs and to find out whether they are being met? If yes, please describe these.

Has HCFA conducted special surveys or other activities to determine your information needs and to find out whether they are being met? If yes, please describe these.

What mechanisms do you use to communicate your information needs to HCFA?
- Which are most effective in obtaining information?

Communication Tools

What mechanisms or forms of communication does HCFA use to provide information to you routinely? In response to specific inquiries?

- For each, what types of information are conveyed?
- Which do you find most useful, and why?
- Which do you find least useful, and why?

Evaluation and Feedback

Have you evaluated the information provided to you by HCFA in formal or informal ways?

- What evaluation methods have you used?
- Have you communicated the results of evaluations to HCFA?
- Has HCFA been responsive to your communications?

From your perspective, what would be the most beneficial outcome of this study?

Interview Protocol for Fiscal Intermediaries

Target Questions:

What types of information do you require from HCFA about Medicare hospital issues?

What mechanisms does HCFA use to communicate this information?
- Which are the most and least effective?

What mechanisms do you use to communicate your information needs to HCFA?
- How responsive is HCFA to your communications?

Do you have unmet or poorly-met needs for information from HCFA?

What types of information from HCFA do you provide to the hospitals you serve?

Information Needs of Fiscal Intermediaries

What categories of information do you require from HCFA?

Do you have formal or informal mechanisms for assessing your information needs? If yes, please describe these.

Do hospitals request information from you about HCFA policies or procedures related to Medicare?
- What types of information?

Do you carry out any activities to determine hospitals' needs for information from HCFA? If yes, what form do these activities take?

Interactions With HCFA

From which HCFA offices do you receive information (in order of importance)?

From which HCFA offices do you request information (in order of importance)?
- How do you decide which office to contact?
- What types of information do you seek from each?

Does HCFA have mechanisms to regularly survey your information needs and to find out whether they are being met? If yes, please describe these.

Has HCFA conducted special surveys or other activities to determine your information needs and to find out whether they are being met? If yes, please describe these.

What mechanisms do you use to communicate your information needs to HCFA?

- Which are most effective in obtaining information?

In what ways is HCFA responsive or not responsive to your information needs.

Communication Tools

What mechanisms or forms of communication does HCFA use to provide information to you routinely? In response to specific inquiries?

- For each, what types of information are conveyed?
- Which do you find most useful, and why?
- Which do you find least useful, and why?

Do you distribute information from HCFA to hospitals?

- What is the content of this information?
- What formats do you use to transmit this information?

Evaluation and Feedback

Have you evaluated the information provided to you by HCFA in formal or informal ways?

- What evaluation methods have you used?
- Have you communicated the results of evaluations to HCFA?
- Has HCFA been responsive to your communications?

From your perspective, what would be the most beneficial outcome of this study?

Interview Protocol for Associations

Target Questions:

What types of information do you and your members require from HCFA regarding Medicare?

How does HCFA supply information?

How effectively does HCFA provide information to you and your members?
- How do you judge effectiveness?

Do you have unmet or poorly-met information needs for information from HCFA?

Relationship of Association to Members and to HCFA

How do you interact with your members with regard to information from HCFA on Medicare?
- Are you involved directly as an intermediary between HCFA and your members in relation to information about Medicare?
- Do members come to you with specific requests for information from HCFA?
- Do you discuss HCFA information issues formally at, e.g., annual meetings, or in printed material provided to your members?

Does the association have a direct relationship with HCFA? Does the relationship involve discussion about Medicare information for your members?

Gathering Data on Information Needs of Members

Do you formally or informally gather data on the information needed by your members from HCFA regarding Medicare?
- What mechanisms do you use to gather information?

What types of information do your members require from HCFA (ranked in order of importance)?

Interactions With HCFA

Do you have mechanisms for interacting with HCFA to inform them of your members' needs? To make suggestions for improving information provision? If so, what are they?

With which HCFA offices do you interact for Medicare information (ranked in order of importance)?

What are the mechanisms by which HCFA responds to your information requests or suggestions?

Co nmunication Tools

What methods do you use to disseminate Medicare information from HCFA to your members?

Which of these tools have been most effective, and why?

Has your association developed particularly innovative or successful means of communicating, which might be adopted by HCFA? Please describe these.

Is your association pursuing new initiatives for communicating information about Medicare to your members?

Evaluation and Feedback

Have you evaluated, either formally or informally, the tools you use to communicate Medicare information to your members?

From your perspective, what would be the most beneficial outcome of this study?

APPENDIX E

CURRENT HCFA COMMUNICATION PROCESSES AND METHODS

APPENDIX E

CURRENT HCFA COMMUNICATION PROCESSES AND METHODS

Overview

Two major areas of communication exist between HCFA and hospitals--financing and quality assurance. This chapter outlines the process and communication methods between HCFA and its partners in disseminating financing and quality assurance information to hospitals through the various branches of the Central Office, Regional Offices, Fiscal Intermediaries, Peer Review Organizations, Associations, State Survey Agencies, and others[2]. Information was obtained through interviews with representatives of these organizations and a review of their transmittals, memoranda, and other internal documents. Figure E-1 illustrates hospital interactions with the Medicare program and the sources of Medicare information for hospitals. Table E-1 summarizes key written materials provided by HCFA to hospitals. Some additional materials published for the Medicare program in general or other areas of program operations are accessible to hospitals on-line via HCFA's web page.

Figure E-1: Hospital Sources of Medicare Information

[2] The descriptions of the HCFA processes and communication methods contained in this report were developed based upon conversations held with HCFA staff members in January, 1997. Since that time, HCFA has undergone major reorganization and therefore some of the distribution of responsibilities and titles of sections of Central Office may have charged.

Table E-1: List of Written Materials Provided by HCFA to Hospitals

HCFA PUBLICATION	PURPOSE
1. Medicare Hospital Manual	1. Contains policies and procedures applicable to the delivery of hospital services, claims instructions, billing procedures, coverage requirements, and related Medicare policies.
2. Medicare Provider Reimbursement Manual: Part I	2. Contains instructions for determining the reasonable costs for provider services, including provider payment determinations and appeals procedures.
3. Medicare Provider Reimbursement Manual: Part II	3. Contains instructions on how to complete the cost report form HCFA-2552 to be filed in an annual basis by hospitals and hospital health care complexes. Also introduces the Provider Cost Report Reimbursement Questionnaire, HCFA 339, to assist hospitals in the preparation of an acceptable cost report and minimize the direct contact between the provider and the intermediary.
4. Medicare Hospital Manual Transmittals	4. Changes in policy are formally incorporated into the Hospital Manual through transmittals that describe new instruction and its date of effectiveness. These transmittals are forwarded to FIs, who then provide copies to the hospitals. Inform hospital of these changes through quarterly provider bulletins or special memoranda.
5. Program Memoranda	5. Billing/reimbursement instructions requiring more immediate implementation are communicated via Program Memorandums to FIs. FIs then inform hospital of these changes through quarterly provider bulletins or special memoranda.
6. Medicare End Stage Renal Disease Network Organizations Manual	6. The manual, under development, provides project officers with technical instructions and/or changes in procedures.

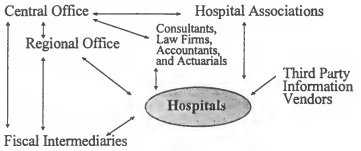
Financing

HCFA Central Office

The HCFA Central Office provides national operational and policy guidance for the administration of the Medicare program and oversees programs designed to ensure Medicare's

fiscal integrity (see Figure E-2). Several of its offices and centers, including the Bureau of Program Operations, Bureau of Policy Development, Provider Reimbursement Review Board, and Freedom of Information and Privacy Office, operate closely with ROs, FIs, hospitals, and their representatives in communicating Medicare policy.

Figure E-2: Communication on Financing



The Bureau of Program Operations (BPO). The BPO provides national direction and technical guidance for administration of the Medicare program. Its broad responsibilities include financial management of Medicare; providing guidance to the government on the purchase of claims processing services from the private sector; monitoring program oversight and improvement; direction of contractor performance standards; and recommendations on penalties and awards.

BPO communicates on these topics with hospitals and other Medicare partners through the preparation and revision of manuals, most notably the Medicare Hospital Manual. Issued to hospitals participating in the Medicare program, the Medicare Hospital Manual contains policies and procedures applicable to the delivery of hospital services, claims instructions, billing procedures, and related Medicare matters.

Other communication activities occur around special projects. For the 1996 Flu Campaign, BPO representatives conducted site visits to hospitals, community centers, and nursing homes to learn more about how providers were implementing the flu vaccine benefit. Besides writing project memoranda, BPO also develops Q&A fact sheets to explain new billing instructions to providers. Q&A are distributed to providers by Regional Offices and FIs

The Bureau of Policy Development (BPD). Establishes national program policy on all issues of Medicare payment including provider payment, provider accounting and audit, and physician and medical services payment. Its Office of Hospital Policy develops, evaluates, and

maintains policies pertaining to the prospective payment system (PPS)[3] for inpatient hospital services and the payment of graduate medical education. It also evaluates and maintains policies for determining and applying rates of increase and limitations to the costs of hospital services not reimbursed under PPS.

Manuals and policy issuances from BPO and BPD reach hospitals through the following path:

1. An official policy change published as a final rule, following an official comment period and revision, in the Federal Register is interpreted by BPO for corresponding billing instructions to Fiscal Intermediaries (FIs). Manual instructions may also be prepared in response to new legislation or coverage clarification which do not always require rule or regulation changes.
2. Changes in policy are formally incorporated into the Medicare Hospital Manual through transmittals that describe the new instruction and its date of effectiveness. BPO transmittals are distributed to FIs quarterly.
3. Instructions requiring more immediate implementation are communicated via Program Memorandum to FIs. FIs then inform hospitals of these changes through quarterly provider bulletins or special memoranda. In these instances preparation of a complete manual instruction is not feasible due to short turn around time. However, most Program memoranda are later incorporated into a manual instruction.

Division of Prospective Payment System. The majority of communication between the Division of Prospective Payment System and hospitals pertains to PPS rates. Annual updates to PPS are published in the Federal Register allowing individual hospitals, trade associations, and other interested parties the opportunity to comment and review data files. During this period, HCFA receives between 200-300 letters, often as a result of write-in campaigns. HCFA must answer all letters, explaining the reasoning behind the proposed changes. Comments are often included in the preamble to the final rule. The Division publishes the annual updates in the Federal Register. PPS rate information is available through public use data files (see Table E-2).

Division of Hospital Services. The Division of Hospital Services is responsible for policies, regulations, and rules pertaining to the capital prospective payment system for inpatient hospital services, payment for graduate medical education, the exclusion of certain hospitals from PPS, and exceptions and adjustments to PPS rates. Since changes in graduate medical education (GME) rates and regulations are infrequent, hospitals and the Office have limited interactions pertaining to GME. Generally, the Division of Hospital Services receives and responds to correspondence from medical residents and specialty societies. Some of the Division's program memoranda regarding graduate medical education policy have been disseminated via the internet by medical specialty societies.

Regional Offices may contact the Division of Hospital Services directly to obtain written clarification for specific regulations on behalf of providers. The Division answers these requests

[3] In response to rapid growth in federal expenditures for the Medicare Hospital Insurance Program, the Tax Equity and Fiscal Responsibility Act of 1982 required the development of a prospective payment system (PPS) for Medicare reimbursement to hospital and other institutional providers. PPS pays providers a predetermined rate per discharge, based on a classification system that groups individuals by diagnosis.

through a memorandum which is automatically forwarded to all Regional Offices and FIs across the country.

Since specialty hospital units, such as psychiatric and rehabilitation centers, are not reimbursed under PPS, the Division of Hospital Services formulates and evaluates national policies pertaining to the exclusion of these special units from the PPS. In order to resolve these exclusions, hospitals have regular phone contact with the Division, usually through lawyers and consultants.

Table E-2: PPS Public Use Data Files

Data Files	Contents
HCFA Hospital Wage Index Survey File	Contains the hospital hours and salaries used to create the PPS indices.
Hospital Wage Indices File	Contains a history of all wage indices used since October 1, 1983.
PPS SSA/FIPS MSA State and County Crosswalk File	Contains state and county codes used by the Social Security Administration and the Federal Information Processing Standards by county name and metropolitan statistical area.
Reclassified Hospital by Provider File	Contains a file of hospitals reclassified for the purpose of assigning a new wage index.
HCFA Case-Mix Index File	Contains the Medicare case-mix index by provider number as published in each year's update of the PPS. The case-mix index measures the costliness of cases treated by a hospital, relative to the cost of the national average of all hospital cases.
ICD-9-CM Version 14.0 File	Contains four associated files: major diagnostic category, diagnostic related group, and ICD-9-CM diagnostic and procedure codes.
PPS - Payment Impact File	Contains data used in estimating FY 1997 payments under PPS for operation and capital.
PPS - Standardizing File	Contains information that standardizes the charges used to calculate tentative weights to determine payments under PPS. Variables include COLA, case-mix index, DSH, and MSA.
Provider Specific File	Contains a component of the PRICER program used by FIs to compute individual DRG payments. Includes records for all PPS eligible hospitals.
After Outlier Removed/Before Outlier Removed Tables	Contains data used to develop the DRG relative weights.
DRGs Relative Weight File	Contains DRGs' narrative description, relative weight, geometric mean, length of stay, and day outlier trim points.

Division of Cost Principles and Reporting. The Division of Cost Principles and Reporting develops policies pertaining to the use of all cost reporting forms, schedules, and other related instructions necessary for the reimbursement of providers. The division is also responsible for writing and updating the Provider Reimbursement Manual, which contains reimbursement guidelines for all provider services under Part A and exhibits and instructions for the completion of the cost reporting forms.

All hospitals participating in Medicare must submit an annual cost report to receive payment for services rendered to beneficiaries. The steps involved in this cost reporting process are outlined below.

1. ***Cost Reporting Forms and Instructions:*** The Division prepares, updates, and distributes the provider cost reporting forms and instructions used by hospitals in the Medicare program. When cost reporting regulations are changed, the Division interprets the law and develops policy directives which are communicated via transmittals to hospitals and FIs. The Division last conducted a major revision of the regulations in 1992.

   The cost report forms and instructions are found in Part II of the Provider Reimbursement Manual. Although there have been various attempts to reduce the paperwork involved in the cost reporting process, the forms and instructions number 779 pages. The development of electronic reporting and computer accounting systems has helped to streamline the cost reporting process.

2. ***Electronic Reporting to Fiscal Intermediaries:*** Conforming to the conditions and principles set forth in the Provider Reimbursement Manual, hospitals are required to submit an electronic cost report to their FIs every year. (HCFA may waive the electronic reporting requirement if the electronic submission results in financial hardship to the hospital institution.) Hospitals must submit the cost report within 150 days of the end of the fiscal year.

3. ***Cost Report Audits:*** Fiscal Intermediaries are responsible for auditing the hospital cost report data before it is submitted to the HCFA Central Office. The provider audit function includes: field audits, desk reviews, and settlements.

4. ***Disclosure of Cost Report Information:*** At the Central Office, the Bureau of Data Management and Strategy (BDMS) edits and processes the cost report data. An important part of this data processing function is the creation of the Minimum Data Set which contains cost, financial, and other information from the Medicare Cost Report. The Minimum Data Set can be purchased through the public use files catalog, which is updated on a quarterly basis by BDMS. Disclosure of any other cost report information is limited by FOIA regulations.

Division of End Stage Renal Disease. The Division develops policies and instructions concerning the coverage of End Stage Renal Disease (ESRD) and organ transplant services for Medicare beneficiaries. The Division determines eligibility criteria and coverage for liver, lung, kidney and heart transplants, while the Regional Offices oversee ESRD networks.

The organ transplant centers apply for Medicare reimbursement based on regulations of organ transplants published in the Federal Register. Based on these regulations, the Division determines corresponding criteria which organ transplant centers must meet in order to receive reimbursement. Transplant surgeon consultants review applications and make recommendations to HCFA, with HCFA making the final selection.

HCFA conducts an annual survey of all facilities certified to provide Medicare-covered renal dialysis and transplantation. The End Stage Renal Disease Facility Survey and its results are distributed through a public use data file, ESRD Facility Survey File. Each record of this file includes facility information and information on the number of patients served, the number of dialysis treatments provided and the number of kidney transplants performed. The survey covers services to both Medicare and non-Medicare patients.

The Office of Correspondence. The Office of Correspondence receives, controls, and tracks all correspondence received by BPD. All correspondence addressed to BPD is first received by the Office of Correspondence and then forwarded to the appropriate parties, including other HCFA components, federal agencies, and state and local officials. An important function of this Office is the management of the BPD internal control system. The Correspondence Assignment Tracking and Control System (CATCS) allows BPD to manage correspondence and assure response. The Office receives requests for information from consultants, lawyers, and accountants; often these inquiries are unique to a provider's operation at a particular point in time.

The Provider Reimbursement Review Board (PRRB). The PRRB conducts hearings to resolve payment disputes between Medicare providers and Fiscal Intermediaries. Upon completion of these hearings, the Board renders decisions that constitute the initial step in HCFA's judicial review process. PRRB issues about 100 decisions every year and providers settle an additional 1,000 appeals each year outside of the PRRB. Approximately 10,000 appeals are pending resolution this year.

When the provider is dissatisfied with the Intermediary's resolution of payment disputes, the provider has the right to appeal the decision to the PRRB when the amount is over $10,000 per cost reporting period. A written request for appeal must be filed with the PRRB within 180 days of the date that the Notice of Amount of Program Reimbursement (NPR) is issued by the Fiscal Intermediary. Upon receipt, the PRRB reviews the hospital's records and sends out a letter of acknowledgment with an assigned case number. When the initial request is completed, the Board asks the hospital to submit a draft list of issues to the Board and the Fiscal Intermediary. The Fiscal Intermediary is required to review the hospital's list and discuss it with the hospital within 60 days from receipt of the list.

However, when a resolution is not reached between the hospital and the fiscal intermediary, the case (with a signed list of issues) is forwarded to the PRRB. Upon receipt of the list, the case is placed on the Board's monthly calendar. Based on this calendar, PRRB sends a Notice of Hearing and Request for Position Papers to the parties involved (fiscal intermediary and hospital) indicating the month in which the case will be heard and when position papers are to be filed.

Position papers, from both the intermediary and the hospital, are due 4 months before the PRRB hearing. To facilitate communication between the Board and the parties involved in this lengthy process, the PRRB office operates an automated phone service where callers can obtain an update of their case.

Composed of five members appointed by the Secretary of DHHS, the PRRB includes at least one certified public accountant and two representatives of service providers. The average hospital appeal is $100,000. Approximately 95 percent of the cases, settle in three years. Though 70 percent of decisions are made in favor of the provider, about 50 percent of decisions are overturned by the HCFA Administrator. The next level of review, if sought, is Federal District Court.

The Division of Freedom of Information and Privacy. (DFOIP) is the HCFA central office responsible for administering the Freedom of Information Act (FOIA). FOIA provides that, upon request from any person, a federal agency most release any agency record unless that record (or portions of it) falls within one of the nine statutory exemptions. HCFA's Freedom of Information (FOI) Officer, who is the director of DFOIP, has the sole authority for granting or denying FOIA requests for HCFA's records. However, due to the large volume of requests that HCFA receives and processes annually, PFOIP has established certain categories of documents that may be directly released to requestors by program offices including HCFA Central and Regional office components and Medicare contractors). The documents in this list are requested frequently and the FOI Officer has determined that they need not be forwarded to DFOIP for review against the FOIA exemptions. Provider cost reports, all policy issuances, summary provider statistical and reimbursement reports, etc., are considered to be direct release documents.

Most hospitals request FOIA documents through their lawyers or business consultants. Hospitals' FOIA requests typically relate to the appeal of a reimbursement or coverage decision. One common complaint among hospitals is that the FOIA requests processed in DFOIP take too long to be completed. Currently, the office has a 1,000 case backlog, with approximately 30,000 requests per year. For those requests processed in DFOIP, the division reviews responsive records, determines if the records (or portions of the records) will be released to the public, and provides responsive notifications to requestors.

Under the Privacy Act of 1974, the Office safeguards the management of records containing information on individuals (i.e., physician or beneficiary) against an unwanted risk on beneficiary privacy. Hospitals, physicians, and suppliers as organizations may not access business information about themselves under the Privacy Act, but may retrieve information accessible through the provider's unique identifier under FOIA. Records containing individually specific information may not be disclosed unless the requestor has either the consent of beneficiaries to whom the information applies or the requester qualifies under one of the twelve disclosure exemptions of the Privacy Act. Questions of public disclosure are directed to the Privacy Coordinator at the Regional Office.

Regional Offices

HCFA's Regional Offices have a limited role in communication with hospitals on financing issues. Most reimbursement questions from providers are routed from Regional Offices to the Central Office. The RO may, but typically does not, oversee the Fiscal Intermediaries in transmitting HCFA CO changes to Medicare hospital policy. When hospitals experience difficulties in carrying out HCFA policy, the RO sometimes takes a more active approach by providing technical and educational assistance to fiscal intermediaries and hospitals. Billing disputes between hospitals and FIs are mediated by the Regional Offices.

The Contractor Performance Evaluation (CPE) is a system of criteria and standards that evaluates contractor effectiveness and efficiency in operating on behalf of the Medicare program. The RO participates in CPE through the evaluation of Medicare contractor fraud and abuse detection, control mechanisms such as post payment review, and many other activities.

Fiscal Intermediaries

Fiscal Intermediaries (FIs) perform bill processing and benefit payment functions for the Hospital Insurance Program of Medicare. The FI is required to ensure payments for covered services to beneficiaries, determine whether services furnished were medically necessary and reasonable, and handle disputes raised by hospitals. Optional functions--determined by agreement with Central Office--may include conducting provider audits, utilization patterns, resolution of cost report disputes, reconsideration of coverage determinations, special reports for Central Office, and dual intermediary responsibilities (when provider networks are served by different intermediaries).

The Fiscal Intermediary (FI) serves as the primary channel for communication between HCFA and hospitals. When the Central Office announces a change in Medicare's hospital policy, the FI is responsible for transmitting this information to hospitals through bulletins, newsletters, or news releases. Intermediaries also provide hospitals with technical assistance through educational programming to ensure that data are accurate and that electronic cost reports are filed correctly, though these activities have been constrained by budget reductions. FIs conduct annual audits of cost reports. FIs and carriers are required to issue at least one Medicare Secondary Payer (MSP) bulletin in each fiscal year.

FIs may employ provider relations and education representatives to provide on-site training for billing procedures as well as to providers who have been the subject of beneficiary complaints or fraud and abuse charges. Additionally, FIs may conduct seminars to refresh knowledge of Medicare regulations, billing procedures, and use of the manuals. Within each FI, a division of provider reimbursement and audit is responsible for provider reimbursement and cost reports, tracking interim payments made to hospitals receiving and processing cost reports, settlements and appeals less than $10,000, and acting as a liaison with the Central Office for provider audits, quality review programs, and Congressional inquiries. FIs may also provide beneficiary and provider assistance through telephone hotlines.

Some FIs train new providers and provide them with required manuals, however there is no required frequency for such training. Intermediaries automatically receive the Hospital Manual, Skilled Nursing Facility Manual, Home Health Agency Manual, and the Provider Reimbursement Manual and any subsequent revisions. Providers deal directly with their intermediary to obtain manuals and revisions and, in the case of a question or issue, can contact their Regional Office.

FI representatives have participated on association committees and have spoken at association meetings on subjects including: 1) hospital turnover of ownership and conversion; 2) denials resulting from clinical reasons or poor documentation; and 3) introducing hospitals to the cost reporting process.

Other Sources of Information

Associations. The American Hospital Association (AHA) is the major trade association for hospitals. Its Washington office, the Center for Public Affairs, deals with national issues and has frequent contact with HCFA's Central Office. AHA serves as a member of the Medicare Technical Advisory Group (MTAG).

AHA routinely tracks *Federal Register* notices published by HCFA and informs its members of the implications of those notices for hospital operations. This includes summarizing the salient features of final rules that affect the way hospitals operate in relation to Medicare. AHA also alerts members to the publication of proposed rules or notices of HCFA's intent to propose rules and suggests that hospitals provide comments to AHA to be passed on to HCFA, or to comment directly to HCFA.

AHA produces a weekly newspaper for members and sends frequent issues of *FAX UPDATE*, which covers political activities in Washington. The Association solicits input from members on various topics, mainly on an ad hoc basis. For example, if HCFA sends a document to AHA for comments, AHA will send it out to select members for their review. Each state has its own hospital association (not affiliates of AHA) and AHA often communicates with the state associations to funnel information to individual hospitals. Hospitals generally have more contact with their state associations than with the AHA directly.

The Healthcare Financial Management Association (HFMA) is a professional society involved with the financial management of a range of provider organizations. HCFA and the Medicare program account for a substantial share of HFMA activities.

HFMA staff interact with HCFA on a regular informal basis, participate as a founding member of the Medicare Technical Advisory Group, and provide input through other formal channels. Many daily interactions stem from requests for information and clarification from HFMA members and often concern Medicare billing rules. HCFA's website is useful to HFMA for obtaining news (e.g., testimony, press releases) and general information (e.g., fact sheets). HFMA uses the website as a primary source of information for their own publications, and refers members to it for general information. In addition to dealing with the Central Office directly, HFMA gathers

Medicare information from the Federal Register, Commerce Clearinghouse publications, and commercial versions of the Medicare hospital billing manual.

Through a range of services, HFMA informs its members of significant developments in the Medicare program. Publications include a monthly magazine, weekly news updates (*HFMA Express News*), and various other newsletters. Other media include a telephone recorded "newsline," "Fax-It" (a document retrieval service for large numbers of printed materials by fax), a telephone help line, and the most recent addition, a web page. On-line interactive internet sessions have recently begun, with an HFMA professional available for questions. The Association holds national and local chapter meetings, which may include HCFA or Fiscal Intermediary representatives.

Consultants and Trade Press. Some hospitals rely on accounting firms, consultants, and lawyers to track updates to Medicare regulations and to prepare cost reports. Those that hire consultants may be able to prepare cost reports more quickly because of the consultants' prior knowledge of and connections to HCFA. In addition to information produced by consultants, hospitals can also reference the St. Anthony's Medicare Manual, Commerce Clearinghouse publications, the Medicare/Medicaid CD-ROM Library, and other communications produced by trade press and third-party vendors.

Quality

HCFA Central Office

The Central Office provides operational direction and policy guidance of Peer Review Organizations and related quality assurance programs to assure the delivery of quality, safety, and appropriateness in health care services (see Figure E-3). Its Health Standards and Quality Bureau has primary responsibility for these goals.

Figure E-3: Communication on Quality

Health Standards and Quality Bureau (HSQB). The HSQB provides overall programmatic direction for implementation and enforcement of health quality and safety standards for providers and suppliers who participate in the Medicare program. Responsibilities include administering and evaluating the national Medicare survey and certification program; monitoring certification of participating providers and suppliers for compliance with established conditions and standards; and implementing, operating, and evaluating professional review and other medical review programs. HSQB conveys operational policy and official interpretations of policy to Regional Offices and State Survey and Certification Agencies. HSQB works with both entities to ensure that certification staff is well-trained and that hospitals in the Medicare program are compliant with federal regulations.

Direct communication between HSQB and hospitals is limited. In most cases, hospitals access HSQB information through Regional Offices or State Survey and Certification Agencies. When hospitals do contact officials in HSQB, they tend to do so through their lawyers or consultants. Lawyers usually call or write HSQB for assistance in interpreting HCFA regulations. In the past, many questions have centered on PPS exclusions.

HSQB writes and updates the State Agency and Regional Operation Manuals. These manuals contain an Appendix of Interpretive Guidelines and Survey Procedures to assist State Agency and Regional Office staff in their survey activities. The protocols outline relevant areas and items to be observed under each regulation and, in some cases, include survey methods. The Guidelines detail the general provision of emergency services, administration, basic hospital functions, optional hospital services, and requirements for specialty hospitals (see example in Table E-3).

Table E-3: Example from the Interpretive Guidelines and Survey Procedures

Regulation	Interpretive Guidelines	Survey Procedures
482.12 Condition of Participation: Governing Body The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. However, if a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.	Condition of Participation: Governing Body In the absence of an organized governing body, there must be written documentation that identified the individual or individuals that are responsible for the conduct of the hospital operations.	Condition of Participation: Governing Body Verify that the hospital has an organized governing body or has written documentation that identified the individual or individuals that are responsible for the conduct of the hospital operations.

Due to the landscape format of the interpretive guidelines and survey procedures, it could not be included in the general CD-ROM Medicare Library.

Regional Offices

HCFA's Regional Offices (ROs) assist beneficiaries and providers with Medicare questions, resolve complaints involving providers serving Medicare beneficiaries, and ensure that providers and suppliers participating in Medicare meet HCFA requirements. Regional Offices may contain functional or organizational units such as: customer service, survey and certification, Medicare operations, audit and reimbursement, beneficiary services, managed care, and PRO's.

Direct communication between ROs and hospitals is mostly limited to beneficiary complaints. When a beneficiary files a complaint with the RO about the quality of services received from a hospital, the RO evaluates the complaint and may authorize the State Agency to initiate an investigation. The RO is ultimately responsible for notifying the hospital and the beneficiary about the State Agency's findings. Depending upon the nature of the complaint, the PRO may or may not be involved in the investigation.

The ROs monitor the process for certifying that participating providers and suppliers are in compliance with HCFA's conditions and standards of participation. To accomplish this, ROs collaborate with Central Office's Health Standards and Quality Bureau (HSQB) and the State Survey and Certification Agency. While HSQB assumes primary responsibility for preparing regulation specifications and sending updates to the Hospital Manual directly to hospitals, the Regional Offices review the State Agency's performance and provide training and assistance when necessary. The RO's Survey and Certification unit conducts bi-weekly conference calls with its Central Office counterpart to discuss hospital and other provider certification issues. In addition, the Central Office produces a periodic validation survey report that gives ROs a list of the compliance status of all hospital facilities in their areas.

Each Regional Office includes a Division of Health Standards and Quality to ensure health care providers and suppliers participating in the Medicare program meet HCFA requirements. The

Division accomplishes this by: 1) evaluating the performance of State Survey and Certification Agencies, 2) providing technical assistance and feedback to the State, 3) updating the On-line Survey Certification and Reporting Process database (OSCAR), and 4) communicating the State Agency's findings to HSQB. ROs have the authority to determine if a hospital is in compliance with HCFA requirements.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing physicians and other health care professionals contracted by HCFA to monitor the quality of care provided to Medicare patients by hospitals, skilled nursing facilities, home health agencies, managed care plans, and ambulatory surgical centers. Over the past several years, HCFA has changed the PRO strategic direction from punitive, retrospective audits of individual medical records to collaborative, prospective quality improvement projects. This new role includes analyzing practice patterns, rather than individual cases; assisting in the implementation of practice guidelines; disseminating information; and assisting hospital personnel in identifying and operationalizing quality improvement opportunities.

Communication between PROs and Central Office generally focuses on the overall mission of the Medicare program and nationwide initiatives. PROs will soon receive HCFA CO surveillance data analyzing trends and geographic variations in admission rates for particular conditions, length of stay, and other utilization measures. Trends in data will be used to direct PRO research.

The Contract Officer, located at the Central Office, is responsible for approving the scope of work for each PRO. The Project Officer, located at the RO, authorizes the activities of the PRO and evaluates its performance. A Scientific Officer, also at the Regional Office, advises the Project Officer on the PRO's performance. Four Regional Offices handle all activity for the 38 statewide or multi-state PROs.

PROs are also participating in a number of research and demonstration projects--some undertaken by the PRO itself with HCFA's approval and others undertaken by request of the Central or Regional Offices. In recent years, the Central Office has increasingly asked PROs to participate in special initiatives. For example, the Delmarva Foundation for Medical Care has developed performance measures to implement clinical practice guidelines as a HCFA special initiative. In other examples, the Central Office has linked multiple PROs to carry out projects.

With the change in PRO direction, hospitals are beginning to approach PROs collaboratively rather than adversarially. PROs are initiating contacts and programs within hospitals to collaborate on ways to improve the quality of care. One PRO is undertaking continuing medical education to improve relations between the PRO and hospitals. The PRO has used techniques such as videotapes and audio tapes, as well as more conventional means, for continuing education programs. They are currently planning expanded regional education programs around the state. Shifting the nature of the relationship with hospitals has required one-on-one contacts with the hospitals, in place of simply sending reports. PRO representatives have worked with hospital personnel to identify opportunities for quality improvement (e.g., the regular use of

thrombolytic drugs for patients with acute myocardial infarction) and then helped to develop new procedures to meet the goals set. These projects have generally worked very well, but are obviously quite labor-intensive for the PRO, thus the number they can carry out is limited.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits about 16,000 health care organizations in the United States, including 70 to 80 percent of all hospitals. The main function of JCAHO is to evaluate hospitals and other health care organizations according to specific standards that they have developed over the years. Survey reports are available not only to the organizations themselves, but also to HCFA. In 1994, JCAHO began releasing performance reports (based on the survey reports) on individual accredited organizations. Starting in 1998, all the reports will be available free on the Internet.

Once hospitals receive JCAHO accreditation, they are "deemed" accredited by Medicare (this is not necessarily true for organizations other than hospitals) and are not subject to regular Medicare survey and certification procedures. JCAHO accreditation does not, however, excuse hospitals from complying fully with Medicare conditions of certification, even if certain conditions are not part of JCAHO accreditation. To assure that hospitals are not vulnerable to challenge by HCFA, JCAHO tries to assure that their standards are broadly consistent with HCFA's. In addition, JCAHO is required to inform HCFA in advance of changes to their standards or procedures.

State Certification and Survey Agencies

State Certification and Survey Agencies are responsible for conducting surveys to certify compliance with HCFA's participation requirements. The State Agency is responsible for the annual survey and certification of all non JCAHO-accredited hospitals within their state. Hospitals that have already been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are not included in this process. The State, does however, conduct an validation surveys at a small sample of JCAHO-accredited hospitals. After completing its survey activity, the State forwards findings and recommendations to the RO, and the RO forwards findings to the hospital.

APPENDIX F

HOSPITAL MODULE FOCUS GROUP REPORTS

APPENDIX F

HCFA MARKET RESEARCH FOR PROVIDERS
HOSPITAL MODULE FOCUS GROUP REPORTS

HOSPITAL FINANCE PERSONNEL

In most hospitals in the United States, payments from the Medicare program account for a substantial share of overall revenue. Financial transactions with the program are extremely important to keeping hospitals solvent. Incorrect handling of transactions may result not only in the loss of some revenue, but carries a risk of serious legal penalties, including hospital shutdowns. Hospitals, therefore, need to understand all the rules and regulations pertaining to the Medicare program and to appropriately apply them to financial transactions with their fiscal intermediary (FI).

We conducted three focus groups comprising a total of 20 individuals with extensive experience in hospital financial management to discuss issues related to the communication of information about the Medicare program. The venue was the 1997 Healthcare Financial Management Association's (HFMA) Annual National Institute (June 30- July 2) in Orlando, Florida, which was attended by more than 1,000 individuals from around the country, representing a wide range of organizations and professions in healthcare finance.

The focus group participants were recruited by Westat, using registration information provided by HFMA. We solicited individuals from around the country, and from the range of hospital types (see Exhibit F-1). Small and large hospitals, research and teaching institutions, public and private organizations all were represented. Five participants were Chief Financial Officers, four were Controllers, and the rest held a variety of jobs in finance, billing, and managed care in hospitals, either currently or in the recent past.

Each focus group lasted one hour, and generally followed the focus group guide prepared beforehand (Exhibit F-2). Participants were given lists of communication methods, key document types pertaining to the Medicare program, and some issues that had arisen in earlier phases of this project, to aid the discussion. A moderator and note taker from Westat were present at each focus group, and the sessions were taped.

This report brings together the themes that emerged from the focus groups, and the suggestions for improving Medicare communications that were offered by the participants. The major subject areas are:

- Communication with fiscal intermediaries
- Communication with and information from HCFA
- HCFA communication with beneficiaries
- Suggestions for improvement

The opinions and ideas reported here are strictly those of the focus group participants, and not those of Westat staff.

Introduction

Most of the information about Medicare billing and claims comes to hospitals through FIs, so it is not surprising that the intermediaries—and not HCFA—were the focus of most of the discussions. Hospitals view the FI as an extension of HCFA itself, not as an independent entity. They equate their communication with the FI as communicating with HCFA. The majority of participants had never spoken directly to a HCFA employee, either at Central Office or at their HCFA Regional office. The majority of hospitals—particularly the smaller ones—rely on consultants to help with claims issues that arise.

Communication With Fiscal Intermediaries

Rapport

General rapport with FI staff varies, but many hospital personnel reported good relationships. The quality of the rapport was not always consistent with the FI's performance, however. In once case, for example, a participant reported a congenial relationship, but at the same time, often got incorrect information. In addition, good rapport was reported with the audit staff of one FI, but not necessarily the claims staff (and in another case, vice versa). Rapport is dependent on many things, and often comes down to personal characteristics rather than systematic differences among FIs. Overall, however, FIs are rarely viewed as consistently helpful partners. Wariness characterizes the relationship of the hospitals to FIs, according to the focus group participants.

Interpersonal interactions often play a significant role in the way a hospital is treated by an FI. One participant described the situation in which the FI appeared to retaliate by holding up a GME payment after the hospital's CFO had a clash with the main audit manager. Several other participants were also aware of such cases.

We have a good rapport with our FI. The only concern I have is that many times we get incorrect information. Our reimbursement rep is a very nice person but I think from time to time, instead of telling us she doesn't know, she will give us an answer and it will be wrong.

Incentives and Impartiality

One participant described it as the FI not being a true "intermediary," that is, a neutral party applying the rules. The FI's aim appears to be to reduce expenditures wherever possible, and this results in what appears to be finding all billing "errors" that go against the hospital, but overlooking any that would increase the hospital's revenue. One participant, who had worked for an FI 20 years ago, stated that at that time, FI personnel saw themselves as there to help the hospital. He speculated (and a few others agreed) that HCFA's incentives to the FIs might be partially responsible for this shift in approach.

Consistency

Inconsistency in applying the rules of Medicare was one of the first issues brought up by participants in each focus group. This includes the lack of consistency of handling claims and audits within a single FI, as well as a lack of consistency across the country in how rules are applied generally. Several participants had worked in hospitals in different parts of the country, and knew first-hand that HCFA rules were applied differently. A number of participants also reported that regional inconsistencies were a very common topic of discussion among hospital personnel attending national professional meetings.

Another type of inconsistency occurs in places where there are two FIs: one dealing with the hospitals and the other, with the beneficiaries. Two participants in different parts of the country were in this position, and they stated that the two FIs not infrequently interpreted rules differently, resulting in the hospital and the beneficiary receiving conflicting information.

Timeliness

There are issues about timeliness both on the claims and audit sides. With regard to claims, hospitals often don't receive notice of changes in procedures until shortly before, or even a month or so after, the change is to be implemented, according to several participants. This causes significant additional work, going back through claims that have already been submitted to adjust them. One person cited an example of a recent change in billing for ambulances, which they were notified of three weeks after it went into effect. Most participants agreed that information in the FI bulletins often comes too late for them to implement changes in a timely manner.

A lot of times we'll get information from HCFA after the fact. We'll get a new rule or regulation in November, and it was effective October 1.

Participants complained of audits occurring anywhere from 1 to 4 years after the calendar year being audited. Regardless of how late the audit is, the hospital is given little time—30 days was cited by several people—to make the required adjustments. In addition, if problems are found, the hospitals often must go through every subsequent year's cost reports and adjust them to reflect changes required by the FI.

One participant reported a major leap in efficiency and timeliness when his hospital was assigned to a different audit team within their FI. This team uses "limited scope audits" to target the most problematic areas, rather than comprehensive audits, and is willing to work collaboratively with hospital personnel to resolve problems.

We just had our audit the first week of June (1997) and that was for our 1995 fiscal year. We just completed, on Monday, our 1997 report, but were getting audited for 95. They'll send us the adjustments and we'll have to turn them around in 30 days, something ridiculous. I think to myself, wait a minute, it took you 2 years to get out here and do the audit and we've got to turn around the adjustment report in 30 days. What's fair about this? Then the hospital's on the defensive. We've got to get our stuff together and figure out what we're going to oppose. And we're always guilty unless we prove ourselves innocent. They're the one with the big stick.

Knowledge and Accuracy

Many participants reported receiving incorrect information from FI personnel. Some possible explanations as to why this happened were offered. Three interrelated issues that were commonly voiced were 1) the relatively low professional level of employees, 2) rapid turnover in FI personnel, and 3) lack of sufficient training for new personnel. Participants said some FIs also appear to be short staffed, and personnel simply don't have the time needed to get information to answer questions thoroughly. Two individuals mentioned that reorganizations at the FIs had resulted in the most experienced people retiring, taking with them a large body of knowledge, which was not replaced. FI personnel appear to be reluctant to say that they don't have an answer, and instead, give incorrect information. In the experience of some participants, FI personnel also do not necessarily transfer a caller to someone more knowledgeable, but feel obliged to respond themselves. The people most often answering the phones were said to be clerks, who do not have adequate knowledge of the Medicare program.

Several participants mentioned that FI personnel often cannot provide further explanation or clarification of information contained in FI bulletins. One example was an attempt to clarify billing rules for outpatient dialysis. The FI could not help, and the hospital was left to interpret the provisions on its own. The person who offered this example also mentioned that the audit staff of their FI are very knowledgeable and helpful, but because the provision they were trying to clarify was a new one, the auditors—who themselves were working on audits of earlier years—were not familiar with it.

Communication With and Information From HCFA

Not a single participant had extensive direct dealings with HCFA. About one-third of the participants had at one time spoken to HCFA personnel, either at the Central Office or their Regional Office. Several participants voiced frustration at the difficulty of finding a helpful and knowledgeable person in the large HCFA bureaucracy. They reported being placed on hold for long periods of time, and being transferred many times before reaching a person willing and able to answer a question.

The Medicare manuals are the most prominent printed materials produced directly by HCFA and used by hospitals. The hospital personnel who use the manuals regularly are adept with them, but suggest they could be indexed better and easier to update. Virtually all hospitals also use CD-ROM versions of the manuals, which are produced by HCFA itself and by commercial publishers. Most participants reported that their hospitals use commercial versions (some were

unaware that HCFA published a version of its own), citing easier searching and, in particular, more interpretive material.

Few participants had used the HCFA website, and a number were unaware of its existence. Access to the internet appears to be limited in many hospitals. In most cases, only certain individuals have access, and in others, there is no access at all.

HCFA Communication With Beneficiaries

Participants reported that HCFA's communications with Medicare beneficiaries have certain indirect effects on hospitals. This subject was raised by a small number of people, but most participants were in agreement on the general issues. First, the hospitals find that beneficiaries simply don't understand the Medicare program well enough, and it falls to the hospitals to educate them. Some personal experiences of trying to get information from HCFA or the Medicare carrier on behalf of aged parents underscored the difficulty of getting answers to questions from the program itself.

A second issue is that there is tendency for patients to believe that the hospitals themselves are at fault or acting inappropriately when items are not covered by Medicare. The hospitals believe they are just applying the rules, but the language used in correspondence from Medicare to the beneficiaries often creates or fuels existing suspicion among beneficiaries. Even something as seemingly clear-cut as Medicare's lack of coverage for outpatient drugs is misunderstood by some beneficiaries as a restriction imposed by the hospital. One hospital reported that they have actually absorbed the costs for outpatient drugs on occasion, so as not to alienate an outraged patient.

Another participant described a common problem in his hospital. In his state, different FIs communicate with the hospital and the beneficiary. Often, the beneficiary receives a letter disallowing a claim up to a week before the hospital is notified. The beneficiary brings the letter to the hospital, which may not have sufficient information to explain the situation satisfactorily. Again, in this case, the beneficiary may blame the hospital both for the disallowance and for not being able to explain the reasons behind it.

Training

Participants in all groups complained that neither the FIs nor HCFA offered enough training opportunities for hospital employees. Most would welcome greater access to training both for new personnel and in more advanced areas.

The last time our fiscal intermediary offered us any kind of training was probably 3 or 4 years ago, and the only time they offer us any training is when the Medicare cost report forms change. As far as they're concerned, there's no other issue. I'm not saying they need to have separate meetings for us for training. Our HFMA has three state meetings a year. They could just have a set half-day program at every state meeting which would be the intermediary's chance to update all the people on all the latest changes and how we should handle them—not just what they are—and this would be communicating to the whole state, one time, everyone would be hearing the same thing. At each of our statewide meetings, the state hospital association has a Friday morning 2-hour session where they go through state changes. So the intermediary or HCFA could do that, too.

New Information Hospitals Would Like From HCFA

At the end of each focus group session, participants were asked about information they'd like but don't currently get about the Medicare program, and for suggestions for change that they believed would lead to a major improvement in communication. In the first category, new information, they asked for the following:

- A newsletter from HCFA, like the CCH newsletter, with executive summaries of new regulations. This would especially help small facilities, which may not be able to afford the subscription price of a commercially published newsletter.
- More information about the extent and limits of Medicare coverage that the hospital can supply to beneficiaries.
- To receive copies of the same information on policy changes that HCFA sends to FIs.
- Names and phone numbers of resource people for different topics at HCFA.

One Improvement HCFA Could Make in Communication About Medicare

Many constructive suggestions were made to improve communication about Medicare. The most frequent general suggestions had to do with generally improving the relationship between hospitals and HCFA, to become more collaborative and less punitive. More concrete suggestions were offered relating to the clarity and timing of information received about Medicare, mainly from the FIs. The specific ideas offered for HCFA were:

- Explain the rules more fully. The JCAHO manual is a good example to follow, with a statement of the rule followed by examples. This type of explanatory material could be placed on the HCFA website.
- Improve the way HCFA explains the program to beneficiaries.
- Be clearer in their explanations to FI personnel on changes in rules, so that the intermediary can better explain the changes to hospitals.
- Work to make billing decisions consistent across FIs.
- Assure that its employees dealing with Part A of Medicare have a working knowledge of how hospitals operate.

- Tape all teleconferences and make them available to those unable to attend.
- When fraud and abuse allegations have been made that turn out not to be accurate, HCFA could publicly accept some of the blame, e.g., for problems arising because of its own mistakes, or because of unclear explanations about what is and isn't allowed.

Summary

Hospitals generally have little direct contact with HCFA, either the ROs or CO. For all practical purposes, the FI is their sole interface with Medicare. The exception is enforcement actions undertaken directly by HCFA, and other sporadic communications. Hospitals may not be aware of which Medicare information they get from their FI is actually coming as a pass-through from HCFA, and which is generated by the FI itself. The comments and suggestions made by the focus group participants apply both to the program as a whole and the FI.

The clearest message we heard is that hospitals do not believe that they are treated as partners by HCFA and the FI, but feel as though they are under constant suspicion of wrongdoing. Focus group participants believed that improved collaboration with hospitals and better appreciation of their operation would go a long way toward improving all facets of how the Medicare program works.

Hospitals would welcome more specific guidance on implementing new or complicated Medicare policies. They believe that many instances of alleged fraud and abuse in Medicare arise from poorly-articulated policies that the hospitals have difficulty clarifying. They also felt that clearer explanations of audit and reimbursement policies might substantially reduce hospitals' vulnerability to allegations of fraud and abuse, which they believe are often the result of inadvertent errors.

A common complaint was that high rates of turnover and inadequate training of FI personnel lead to inaccurate or misleading communications to hospitals. While the hospitals rarely attempt to get information directly from HCFA, some of those who did felt that there was also a problem with HCFA personnel, both at the RO and CO levels, not being fully informed about the program, and being unable to resolve issues for hospitals (or providing incorrect information).

Participants from the hospitals felt they were under constant pressure to produce information according to a strict schedule. However, they complained that the FIs, and possibly HCFA itself, do not adhere to these schedules. Several hospital representatives reported cost report audits taking place three or four years beyond the calendar year of the report. Even in those instances, however, the hospitals were given very little time to respond to queries and to make corrections once the report was delivered to them.

Timeliness is also a problem in the implementation of new policies. Hospitals report receiving the information that a change is required days before, and sometimes after, the date the change is to be put into effect.

The hospital representatives in these focus groups expressed a desire to improve communication with the FIs and with HCFA. They would like the program itself and the communications they receive to be more transparent, and have made a number of suggestions that they believe would move in that direction.

EXHIBIT F-1

CHARACTERISTICS OF HOSPITAL FOCUS GROUP PARTICIPANTS

State	No. of Beds	Location/Type	% Revenue from Medicare	Title of Participant
California	NA	NA	NA	Controller
	1,000	research and teaching	40	Associate Director of Finance
	350	isolated public	25	Controller
Florida	323	NA	53	Reimbursement Specialist
Indiana	100	suburban	NA	Director of Accounting
Iowa	90	rural public	65	CFO and Assistant administrator
Kansas	121	small chain	73	CFO
Kentucky	75	county	NA	CFO
Louisiana	231	acute care	NA	Controller
Mississippi	490	acute care	45	VP Finance
Nebraska	300	city-owned	NA	Managed Care Officer
Nevada	650	acute care	28	Director, Patient Financial Services
New Mexico	283	acute care	50	Chief Accountant
Ohio	1,000	specialty center	NA	Finance Manager
Oklahoma	NA	42-provider multispecialty clinic	NA	CFO
S. Carolina	525	acute care	38	Billing Director
S. Dakota	225 + 85 ltc	acute and long-term care	NA	Director Accounting
Texas	NA	fully-integrated health system	40	Director, Managed Care
Virginia	260	affluent area	40	Controller
West Virginia	233	NA	NA	CFO

NA = not ascertained

EXHIBIT F-2

HCFA MARKET RESEARCH FOR PROVIDERS
HOSPITAL FOCUS GROUP DISCUSSION GUIDE

Introduction

My name is Garrett Moran and I will be moderating this focus group. My colleague, Hellen Gelband and I work for Westat, an independent research firm. This project is funded by the Health Care Financing Administration (HCFA), as one part of a broad effort to improve their communications with their partners in operating the Medicare program, including hospitals, doctors, and others.

Our major focus will be on communications, rather than on specific policies. The goal of this session is to find out from you how HCFA might improve the way it communicates with hospitals, both directly and through other organizations, including the fiscal intermediaries, peer review organizations, state survey agencies, or others. We'd like to know both where there are problems in communications, and what you think works well.

Before we get started, you should know that everything you say will be kept confidential. Neither your names nor the names of your organizations will be listed in our report, so please feel free to speak frankly.

Discussion Guide

Let's start by having you introduce yourselves and the organizations you work for. Please tell us your name, what type of hospital you work for, how big it is, your role in the organization, and where it's located. One of our interests is in the ways that communications differ across the country. You don't have to give the actual name of your organization, but it's fine if you'd like to.

Let's start by thinking about some of the different ways you get information about the Medicare program. On side one of the sheet in front of you is a list of some of the different methods HCFA or its contractors use to communicate information. Which of these methods do you use, and which do you like or not, and why?

Side 1: Communication Methods
(on handout given to participants)

Written materials, such as paper version of the Hospital Manual, FI bulletins, or correspondence sent by regular mail
CD-ROM, such as CD-ROM version of the Hospital Manual
HCFA worldwide web site
Verbal communications, either in person or by telephone
E-mail, and electronic data transfers, including the Common working file (CWF)
Fax distribution of materials
Conferences and training sessions
Others

[Record answers on flip chart. Spend 10 - 15 minutes letting everyone who wants to contribute do so].

Now let's change to a discussion of some of the more important Medicare communications processes or operational areas. On side two of the sheet in front of you is a list of processes or areas that others have considered important. Are there items on this list, or others you might think of that are important to you, where the communications have worked especially well, or where communications really need to be better? I'd also like you to think specifically of information in any of these areas, or others, that you need from HCFA, but aren't getting now.

Side 2: Communication Processes and Operational Areas
(on handout given to participants)

Claims and billing
Beneficiary communications
Quality assurance and improvement, including PROs
Regulatory and policy issues and changes (communicating with HCFA central office, regional offices, and FIs)
Cost reporting
FI audits & appeals
Medicare as a secondary payer (MSP)
Managed care
Survey/Certification
Fraud and abuse
Research
Graduate medical education
Others

[Record answers on flip chart. Spend 15 - 20 minutes letting everyone who wants to contribute do so].

Thank you very much. I think you've all made some very good points. In the few minutes we have left, I would like you to think about one or two things that HCFA could do that would help most in improving communications with hospitals. Of all the things we've discussed today, or others that haven't come up yet, what one or two activities do you think would be most helpful?

[Record answers on flip chart. Spend 10 minutes letting everyone who wants to contribute do so].

Thank you all very much for your participation. I think the information you've provided today will be very helpful to HCFA in improving their communications with you. Enjoy the rest of your meeting.

FISCAL INTERMEDIARIES

In most hospitals in the United States, payments from the Medicare program account for a substantial share of overall revenue. However, most hospital personnel responsible for finance and accounting will never, or only rarely, communicate directly with individuals at HCFA itself, either the Central or Regional Office. To hospitals, HCFA is represented exclusively by the fiscal intermediary (FI). Virtually all official Medicare information comes from the FI, and hospital personnel do not know, and are not necessarily concerned with, with the original source of that information.

In focus groups with hospital personnel, most of the issues raised had to do with communication between the hospital and the FI. Those participants, however, were not in a position to know whether the problems were rooted within the FI itself, or whether they reached back to the FI's relationship with HCFA, and the information flow between those entities. For HCFA to fully understand and address the communications issues of hospitals, it is imperative to understand the FI perspective on their role in between HCFA and hospitals. To gather this information, we conducted two focus groups with personnel from FIs to find out about how HCFA communicates with them and how they, in turn, communicate with the hospitals they serve.

The first focus group, which lasted an hour and a half, took place at a Blue Cross/Blue Shield Association (BCBSA) regional training meeting for Medicare auditors, in Whitefish, Montana, on July 30, 1997. Six individuals from HCFA region 8 (Denver) attended. We held a second one-hour focus group by telephone conference on August 11, with 11 individuals from Blue Cross/Blue Shield (BC/BS) FIs in seven states in regions 2, 4, 5, 7, and 9 (see Exhibit F-3). The discussion guides for these focus groups are included as Exhibits F-4 and F-5 of this report.

Westat recruited individuals for the Montana focus group from the registration list for the training meeting, which was supplied by BCBSA. BCBSA also provided a list of suggested participants for the telephone focus group. Most participants had many years of experience with their respective companies working for the Medicare program, and a few had had similar jobs with FIs in other parts of the country. For practical reasons, it was not possible to recruit individuals from non-BC/BS intermediaries, but since the majority of intermediaries are currently BC/BS plans, this should not introduce significant bias into the results.

This report summarizes the discussions at both FI focus groups, including suggestions for improving Medicare communications that were offered by the participants. The major subject areas are:

- Communication flow from HCFA to FIs,
- Opportunities for direct contact with HCFA,
- Communication with hospitals,
- New information FIs would like from HCFA, and
- Desired changes in communication process.

Introduction

The discussions covered a variety of issues related to communications from HCFA: sources and types of communications, timeliness of information, and clarity and usability of information. This included paper and electronic items on specific topics, as well as the general area of exchanging information with HCFA, e.g., in educational forums and through advisory groups. There was less discussion about FI communications with the hospitals they serve, since most such communication is routine, and there are a limited number of ways in which information is transferred.

Communication Flow From HCFA to FIs

Information Flow

Most information flows to the FIs through the HCFA Regional Offices (ROs). One participant estimated that about 75 percent of the communications arrive from the RO, and the rest come from HCFA Central Office (CO). At least several hundred communications are received each year. Messages are sent as needed, not on a regular schedule. Over the last few years, most of the communication has been coming in electronic format only.

It was the impression of the participants that some ROs routinely pass on communications they get from HCFA CO unaltered, or with comments attached, while other ROs rewrite much of the information before sending it to the FI.

Paper vs. Electronic Communications

There was a consensus among the telephone focus group participants that, in general, only material received in hard copy was considered "official." E-mail messages from ROs are written much more informally, and it is not always clear to recipients whether the information should be considered official. One person stated that she did not believe there was an equivalent review and sign-off process for e-mail as there was for hard copy mail within the RO office. Greater confidence in e-mail information on the part of the FI personnel might be engendered by a more formal presentation and knowledge of how the information was generated.

On e-mail transmissions that are more informal--instructions and memos—I find that they don't have all the details that you'd like. Also, many times when we get those, I'm wondering if they're "official communications." Many times you get them from people you don't even know. That concerns me.

E-mail seems to be much more informal than if you get something in writing with someone's signature on it.

Content of Communications

Participants reported that much of what is received is clear and easily interpreted. However, a significant number of items each year, including changes in billing and cost reporting policy, are very difficult to interpret and apply in the situations that arise in the course of Medicare

transactions with hospitals. They felt that HCFA does not provide enough information to the FI to inform the provider about how to properly bill for services. The communication will state the rule, but provides no examples or clarification. The FI must resolve uncertainties by researching and asking questions, and then ultimately communicating their interpretation in the FI bulletin. At times, FIs may have to change their interpretation when new information is received, and participants reported that this tends to erode the relationship with hospitals, who see the FI as not understanding the rule.

Another complication reported by participants arose when some of the letters from HCFA contained a disclaimer stating that FI cannot use the letter as reference, i.e., they cannot show it to the hospital or identify the letter as the source of a change. Not surprisingly, providers often ask for documentation before implementing a change, and the FI has nothing that it can show. Participants feel that these episodes may damage the relationship between the FI and the provider.

Participants reported that HCFA policies are usually stated in very general terms, and it is sometimes impossible to know what HCFA wants. An example given by a participant was a new policy on levels of pension plan funding for hospital employees (which can affect allowable costs under Medicare) that came as a manual revision. The policy statement seemed unclear and used terminology the participant didn't think was appropriate to the actuarial issue it was addressing. In the participant's judgment, it appeared to have been written by someone who did not have a clear understanding of the issue, and it caused significant problems for the auditor attempting to implement it correctly.

Many times, the communication that we get and have to implement takes a lot more explanation than we get from HCFA: how does the directive translate to the provider being able to bill for the service? From an education perspective, it's up to us to interpret how it applies to billing. That leads to the need for clarification and reclarification of one issue or another, and often we have to do that without further help from HCFA.

Many times HCFA uses the words "contractor" and "carrier" interchangeably. Sometimes if they're talking just to the Part A intermediaries, it's very hard to discern whether they're just talking to Part A intermediaries or to Part B carriers. I have a situation right now, where I had been asked for a deliverable for August 8, and finally have come to the conclusion, after input from the regional office, that it is intended for Part B. In our state, Part B is a different organization.

Timeliness of Communication

Three issues related to timing were raised during the focus groups. First, there are sometimes problems of insufficient lead time to implement new policies. An example was when HCFA changed the prospective payment for capital and the FIs had little time to implement the change. The FIs are anticipating a similar short lead time when HCFA releases its policy on prospective payment for nursing homes.

The second issue deals with HCFA pushing back the implementation dates for new policies. In these cases, FIs may be notified of a change, and they then notify their hospitals. HCFA then notifies the FI of a delay in implementation, and the FI must go back to the hospital—which may already have made the appropriate changes—with the new implementation date. One participant cited a change in the End Stage Renal Disease program claims process that has been delayed three times.

The third timing issue has to do with short turnaround times for getting information to HCFA. This seemed to be a general theme, related to many kinds of items, with concurrence by most participants. Their consistent concern was that HCFA does not allow sufficient time for FIs to produce the needed information.

Effect of HCFA Communications on Consistency Among FIs

According to the participants, some of the often mentioned inconsistencies in how Medicare claims are handled by FIs appear to arise from differences in interpretation and information provided by ROs. They reported finding out about these differences in various ways. In some cases, an RO will reply to an individual query from an FI and provide information that has substantial policy implications. But that letter will not be routinely provided to other FIs, and may not be consistent with the positions of other ROs. When FIs meet, they often bring with them letters from the RO to share with others, and at this time confirm that information was not provided to all FIs.

A participant from Region I reported a recent example in which only one FI received relevant information on an issue related to occupational and speech therapy. The communication reported addressed a problem that was significant for the entire country, yet only one FI received the explanation.

Participants reported learning of differential handling of issues among FIs when providers are reassigned after FIs have dropped out of the Medicare program. This causes some problems for the providers, as they must change their procedures to accommodate the new FI.

If we had some sort of centralized communication logs, we'd know that HCFA, in fact, put out 5 memos this month, and those 5 were disseminated to all the intermediaries.

Region 5 does send out an "identical letter log" of all the identical letters they've sent out in the month, or quarterly, I'm not sure. That is a big help, because then we go and check and see if there are any we have not received. For Central Office correspondence, we don't have anything like that, though, and of course, we don't know what other regional offices are sending out.

A times, there is something straight from the regional office that is developed there and sent out. The problem with that is one region hears about something but it's not communicated to the other regions, so a lot of times there are inconsistencies amongst the regions. A lot of regions haven't issued any communication, and maybe they don't even agree with what one regional office sends out. That's a problem.

HCFA Web Site

Most FI offices reportedly have access to the internet and can get to the HCFA website. Several FI offices have assigned someone to look at the website regularly, but for the most part, this has not worked satisfactorily. Because it is time-consuming to look through the web site for new items, the task is assigned to a clerical person. But the staff members who have the time may not have enough background to know what to look for. The result is that the website is not browsed as often or as thoroughly as it should be. The participants felt the web site would have to be reorganized if HCFA intends FIs to use it more routinely, or as a substitute for other types of communication. On a positive note, one participant reported success in using the website to find the answer to a question from a provider about a change in rules for Medicare as Secondary Payer.

We have access to it, but we've found it difficult to find somebody... to go through it... It would take a higher level person to look around and see what's out there, and what we would be interested in. The higher level in management doesn't have time to go looking around. If you give it to a lower level person—secretary or clerical—they may not know what to look for, so we've had a real hard time with this. We don't go in there as much as we'd like to.

When we have a question about a policy, we're more apt to browse the MIM or the MCM, which we have on CD-ROM to locate an answer first before we'd ever go to the internet.

Providers were calling us on the MSP change [in the coordination period from 18-30 days], and we were able to find that information on the internet.

HCFA Manuals

Participants reported using both the HCFA and commercial versions of Medicare manuals on CD-ROM, but both the FIs and the hospitals continue to rely heavily on the paper manuals. An issue relating to the paper manuals, which was reported by FI customer service representatives, is that they are never entirely sure that the manual they are using and the one their hospitals are using are the same. This is because updates are sent to them late, and there is no way to know whether there may be updates they have not gotten. They would like confirmation, e.g., that a section dated 1980 really has not been updated since then. To alleviate this problem, it was suggested that an index of sections with most current dates of revision could be produced and kept up to date for distribution the FIs and hospitals.

From my perspective, as an educator to our provider community, the thing that I'd like most would be current manual updates. Facilities get the manual for their type of facility at the time of certification. But we don't get the updates—the pages that should replace older ones—on a regular basis. We're trying to tell the facilities, this is your manual—keep it updated and use it, and we quote from it, only to find that we don't have the most current pages. Medicare takes an awful bad rap because we're saying one thing in the newsletter, but the manual says something else. It would go a long way in providers having more confidence in the Medicare program.

We need to have more timely manual transmittals. We can go to our manual, which we call our "bible," with reference to our providers, only to find that we haven't received an update in 7 or 8 years on an issue, and it just doesn't look good for the program.

Opportunities for Direct Contact With HCFA

There was a consensus at both focus groups that FIs would like to have more direct contact with HCFA, but that over the last few years, their opportunities for interaction have actually diminished. The two types of contact that they spoke about are: 1) interaction to learn about changes in Medicare and to solve problems in face-to-face encounters, and 2) having input into new policies and changes.

Obtaining Information and Resolving Problems

In the first category, participants expressed interest in having more forums for addressing problems and learning about new policies. An example are HCFA audit conferences, which used to be held annually, and were very well attended. The last one was held two years ago. There was considerable support for reinstating these annually.

FIs would like to have regular forums in all relevant areas at which HCFA personnel would be present to answer questions directly. It was also reported that, although HCFA encourages questions to be submitted in writing at national meetings of various kinds, which they promise to answer in writing, these questions are often left unanswered.

Getting answers directly from HCFA is also reported to be a problem at times. One participant expressed frustration with going through the RO for an answer. Several times, the RO has not known the answer, has gone to someone at CO, and then returns with an answer that is not applicable to the original question. This participant felt that HCFA encourages FIs to go through the RO with questions (and discourages direct inquiries to CO), but this is an inefficient system at times, exacerbated by staffing cuts at the RO, with many of the most knowledgeable people having left.

We'd love more chances to communicate with HCFA. The last few years, we've really lost communication with HCFA.

I'd like to see more opportunities for forums for intermediaries and contractors with HCFA in the different substantive areas, maybe on an annual basis.

We need forums to present problems and let HCFA in on them, so they understand where those problems are. Right now, there are no ways for this to happen.

Opportunities for Input Into the Process

According to participants, HCFA does not regularly solicit input from FIs before putting out new policy statements. The FIs believe that certain problems in implementation might be avoided if they were consulted when policies were in the draft stage. Participants felt that more consultation with FIs could result in smoother and more trouble-free implementation of new rules. A recent example offered by one participant had to do with a change in how observation beds are counted for cost reports, but others agreed that this was a more general problem.

Participants complained that some opportunities for input that used to exist have been discontinued. For example, HCFA Technical Advisory Groups (TAGs) were replaced by steering committees, but many or most of these committees do not meet on a regular basis, and don't take the place of the former TAGs, which met quarterly. One participant noted that TAG meetings may have become something of an embarrassment to HCFA, because the same issues were brought up repeatedly, but never resolved.

Some participants had been part of BCBSA's own Reimbursement Advisory Committee (RAC), made up of representatives of BC/BS FIs from each region. Results of RAC meetings are forwarded to HCFA, but HCFA does not participate in the meetings. BCBSA does not have similar groups for subject areas other than audit and reimbursement, e.g., medical review, customer service. According to participants who worked in those areas, they have no regular conduit for feedback to HCFA.

A lot of times, communications about policy changes from the Central Office are given to us without any prior input from the contractors. A specific example of that in the last few months has to do with observation beds. There was a change made by Central Office and I'm not sure consideration was given to the effect it would have on the contractors. I think it would be good to get a lot more input from the contractors before changes are made.

Many times, policies are handed down from Central Office, and when they get to us, they're very difficult to implement. You have to go back to HCFA and talk to them about it, but sometimes the decision's been made and it's so far down the road that it's difficult to go back and have changes made.

Communication With Hospitals

All FIs produce "FI bulletins" of some sort for the hospitals they serve. Most produce these at least monthly, but one FI represented in the focus groups produced theirs bimonthly, following an agreement with their RO. Most others issue bulletins "on demand," which may be more than one per month, if there is a need.

All the FIs represented had or were developing an electronic bulletin board. It was estimated that more than 90 percent of hospitals had computer access to these bulletin boards. Bulletin board

notices are used for timely reporting of critical new information, and are followed by complete reports of changes in the next printed bulletin. FIs believe that only short bulletin board items will be read. Users are likely to bypass long items. Also, there is no guarantee that all users will see each bulletin board item, so it cannot be relied on as the sole means of communicating important information. For items requiring immediate action, at least some FIs use a "Dear Administrator letter."

All the FIs represented claimed that they also put on training seminars for their hospitals. Some organize them "on demand" when requested by hospitals, as well as scheduling them independently and in conjunction with other associations. A typical example in one state were the 13 seminars given around the state in the month of June dealing with Medicare as a Secondary Payer. State chapter Healthcare Financial Management Association meetings were mentioned by several people as regular venues for FI updates. Articles are also placed in various association newsletters.

One FI maintains a hospital liaison committee that meets quarterly. Representatives of the state and local hospital associations and from individual hospitals form the membership. Provider groups in another state meet on a regular basis and the FI presents Medicare updates at their meetings.

New Information FIs Would Like From HCFA

At each focus group, participants were asked to think of information they do not currently get from HCFA, but would like to get. They offered the following:

- ROs should provide identical information to all FIs on relevant topics, i.e., if an individual FI receives a clarification based on an inquiry, the information should be given to all FIs.
- ROs and CO should produce a monthly log of their letters and other communications so FIs can check to make sure they've received all items.
- HCFA should release new policies or other changes while still in the draft stage, for comments.
- When an FI receives clarification of a policy or billing question from the RO, the RO should provide some official indication that the answer is supported by CO and that the issue is handled similarly around the country.
- In documents stating policy changes, HCFA should give more examples.
- Indexes to the various manuals should be produced regularly, including the most recent revision dates for each section.

Desired Changes in Overall Communication Process

Each focus group participant was also asked to name one change in communication that would improve the system for them. The following were suggested:

- Hold annual conferences for each major area of Medicare, with an opportunity for face-to-face two-way interaction.

- Reconstitute the technical advisory groups.
- Allow FIs a reasonable amount of time to respond to various requests from HCFA. Current timeframes are often thought to be unrealistic.
- Send out manual updates more promptly.
- Increase use of electronic communication of reports from FI to HCFA (currently, some reports must be sent in hard copy and on diskette via overnight mail).
- Give FIs more lead time in notifying them of changes.
- In communication from HCFA, be more specific about the appropriate recipient—i.e., don't address correspondence to "contractor/carrier" if it is really just for the carrier and not the FI.

Summary

Several themes emerged from the two focus groups with FI personnel. One message is that there is a perceived need for more collaborative resolution of problems between HCFA and the FIs. Given the complexity of the program and the myriad variations in hospital operations, there will always be a need for direct dialogue to address unanticipated problems. Participants reported that this need for interaction is not being met, and in fact, has eroded over the past few years as annual forums have been discontinued and advisory groups meet less frequently than before.

Inconsistencies in interpreting Medicare policies around the country were also a source of concern to the participants, not only because they cause confusion within the program, but also because they are the target of criticism by the hospital community. Inconsistencies were said to arise, in part, because ROs and FIs apply their own interpretations in the absence of adequate national guidance to clarify ambiguous policies. There appears to be no routine mechanism for sharing this information from one region to another. Participants thought that some of the inconsistencies might be eliminated if these decisions, as well as individual resolution of issues with HCFA, could be captured in a format accessible to FIs across the country. At the very least, FIs would be made aware that interpretations differ, and this could be a topic for discussion at meetings.

The FIs said they would like to play a more active and consistent role in the way new policies are stated and documented before they are sent out in their final form for implementation. They recommended consultation with an advisory group of FI representatives in the initial stages, and wider circulation of later drafts to FIs for their suggestions. They would like policy statements to be accompanied by examples, and thought that the sharing of drafts might be an efficient way to generate a range of examples.

Participants indicated that electronic communication has begun to play an important role in linking HCFA and FIs. This change has been welcomed by FIs, in general, but with the understanding that systems will be continually refined and updated. The HCFA website is found useful, but time-consuming to browse regularly. They suggested that reorganizing the material, and possibly highlighting new material, would improve the usability of the web site. Increased

use of direct electronic submission of reports could streamline some reporting, and save time and money.

Overall, FIs appear eager to improve communications with HCFA. They offered many specific suggestions for improvement, but the clearest message is the need for ongoing interaction and open channels for two-way information exchange.

EXHIBIT F-3

STATES AND JOB TITLES OF FISCAL INTERMEDIARY FOCUS GROUP PARTICIPANTS

States Represented:

Arizona
Georgia
Illinois
Iowa
Montana
New York
North Carolina
South Dakota
Texas

Job Titles:

Audit and Reimbursement Manager
Audit Manager
Customer Service Manager
Customer Service Representative
Customer Support and Communications Manager
Lead Auditor
Medicare Coordinator
Medicare Director
Provider Affairs Representative
Public Relations and Communications Director
Reimbursement Manager
Senior Auditor
VP for Audit and Reimbursement
VP for Federal Programs

EXHIBIT F-4

HCFA MARKET RESEARCH FOR PROVIDERS
FISCAL INTERMEDIARY AUDITORS FOCUS GROUP DISCUSSION GUIDE
JULY 30, 1997

Introduction

My name is Hellen Gelband and I will be moderating this focus group. I work for Westat, an independent research firm. This project is funded by the Health Care Financing Administration (HCFA), as one part of a broad effort to improve communications with their partners—including hospitals, doctors, beneficiaries, and others—in operating the Medicare program.

Our major focus this evening is on communications, not on HCFA policies. The goal is to find out how HCFA might improve the way it communicates with you, both directly and through other organizations, and, in turn, about how you communicate with hospitals about the Medicare program. I'm interested both in how things could be improved and in finding out about communications strategies that have worked well for you in your work as auditors for Medicare.

Before we get started, you should know that nothing you say will be attributed directly to you or to your organization. I will be summarizing what you say in a report to HCFA, but neither your names nor the names of your organizations will appear anywhere in that report. I am tape recording the entire session for my own use in writing the report. The tape itself will remain with Westat.

Discussion Guide

I'd like to start by asking each of you to introduce yourselves. Please tell everyone where you work, what your position is, how long you've been there, etc. If you've had previous jobs that also might be relevant—say, in hospitals dealing with the Medicare program—please go ahead and mention them, as well.

Major Areas and Items of Communication

I'd like to set the agenda for the remainder of the session by making two lists. The first will be reports and other types of communications that you receive, directly or indirectly, from HCFA. Second, the communications you have with hospitals.

[Record answers on flip chart.]

I'd like you to set priorities for discussing these, with high priorities to those that are most problematic, most amenable to improvement, or for other reasons that you specify.

[Number items on flip chart.]

Let's start going through the lists now. All aspects of communication are open in this discussion—the mode, that is, electronic, paper, telephone, etc.; the content; timeliness---anything that affects the way you do your work.

[Ask specifically about the HCFA web page and internet availability, if this does not come up spontaneously. Also ask about the effect of HCFA incentives on their work.]

Wrap-Up

In the few minutes remaining, I'd like to focus on two more items. First, is there information that you currently don't get about the Medicare program, which would be useful to you.

[Allow 10 minutes.]

Last, can you suggest the one or two things that HCFA could do that would improve communications with you the most.

Thank you all very much for your participation. The information you've provided should be very helpful to HCFA in improving their communications with you.

EXHIBIT F-5

HCFA MARKET RESEARCH FOR PROVIDERS
FISCAL INTERMEDIARY TELEPHONE FOCUS GROUP DISCUSSION GUIDE
AUGUST 11, 1997

Introduction

My name is Hellen Gelband and I will be moderating this focus group. My colleague, Garrett Moran is also here and will be participating. We work for Westat, an independent research firm outside of Washington, DC. The work we're doing on the Medicare Program, and that we've asked you to help us with, is under a contract with the Health Care Financing Administration. It's part of a broad effort by HCFA to improve communications with their partners—including hospitals, doctors, beneficiaries, and others—in operating the Medicare program.

Our focus today is on communications, not on HCFA policies. The goal is to find out how HCFA might improve the way it communicates with you, both directly and through other organizations, and, in turn, about how you communicate with hospitals about the Medicare program. We're interested both in how things could be improved and in finding out about communications strategies that have worked well for you in the past.

Before we get started, you should know that nothing you say will be attributed directly to you or to your organization. We will be summarizing what you say in a report to HCFA, but neither your names nor the names of your organizations will appear anywhere in that report. We're tape recording the session only for our own use in writing the report.

You probably know that most focus groups are done in person. This conference call mode makes things a bit more difficult, particularly because of the loss of body language. We'll have to see how the rhythm gets going and try to make sure that no one is left out. Whenever you start a comment, please identify yourself with your first name. We may occasionally "go around the room," so to speak, to poll everyone on a question. If that happens, we'll say each name first.

Discussion Guide

We have 8 [?] people on this conference call. I'd like to start by asking each of you to introduce yourselves. Please tell us where you work, what your position is, how long you've been there, etc. If you've had previous jobs that also might be relevant—say, in hospitals dealing with the Medicare program—please go ahead and mention them, as well.

Major Areas and Items of Communication

I'd like to set the agenda for the next part of the session by making a short list of the types of reports and other communications that you receive, directly or indirectly, from HCFA. To save time, I'll read through a list I've made up and you can react to it and add to it.

- Bulletins from ROs (RILs),
- Federal Register notices,

- Program memos (CO),
- Rulings (CO),
- Manual updates (CO), and
- Prior consults (BCBSA).

[Record answers]

Let's start going through the list now and finding out what the issues are related to each of them. All aspects of communication are open in this discussion—the mode, that is, electronic, paper, telephone, etc.; the content; timeliness—anything that affects the way you do your work. I'm interested in the frequency of the items you get from ROs, particularly where that differs around the country. I'd also like to know which things arrive electronically and which are only on paper.

[Ask specifically about the HCFA web page and internet availability, if this does not come up spontaneously. Also ask about the effect of HCFA incentives on their work.]

****

Next I'd like to find out how you communicate Medicare information to the hospitals you serve. Again, we'd like to know how often you send information to them, the format of the communication, and issues that arise.

****

[next section if time permits; otherwise skip to wrap-up]
We'd like to know what your experience has been in initiating communication with HCFA. Who do you contact when you need any kind of information? How have those contacts gone? Have you gotten the information you need? Have requests been handled efficiently?

****

Wrap-Up

In the few minutes remaining, I'd like to focus on two more items. First, is there information that you currently don't get about the Medicare program, which would be useful to you.

[Allow 10 minutes.]

Last, can you suggest the one or two things that HCFA could do that would improve communications with you the most.

Thank you all very much for your participation. It's been an interesting discussion, and should be very helpful to HCFA.

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